Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02882 State of Maryland / Department of Health and Mental Hygiene 2009 | 500 | William Allen Carter Certificate of Death Reg. No. 1- For State 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 1536 hrs Month April 10, 2009 Medical Examiner William Allen Carter 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY), 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Country Washington 5. Social Security Number **Funeral** Months Days 04/09/1971 999-99-9999 38 Director 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 28a-must be notified at USA 20019 1530 Kenilworth Ave N.E. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Mantal Status White etc. Armed Forces? Pages 1 and 2 should be filed within 72 hours after death neat of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or item 1 X Never Married 2 Married 2 X No Yes Specify: Black Divorced If Yes, Give Year Yes 2 X No specify: Widowed 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) event, the Medical Private Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carter Nancy Arrington Willie Be 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennifer Galloway/GirlFriend 630 Kenyon Street, NW, Wash, DC item 27 is m traumatic 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Washington Nat Cem 4/18/09 Suitland, MD permit. Page Department of Important: Other Specify Donation 5 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee Austin 3821 14th Street, N.W., Washington, DC 20011 Terry A. hiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death **Tedica** a. Multiple Gunshot Wounds Immediate Cause (Final disease **A**miner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and cian/Medical AMENDED g physician a UNPENDED 23d. Date of delivery Box 68760, 23c, if yes, outcome of pregnancy Year Day Month Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by the I be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 V No 3 Probably 4 ğ Records, P. 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? certificate has be ector, page 2 sh 1 🗸 Yes ✓ Yes 2 page 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Residence 6 examiner? Nursing Home 5 Inpatient 2 FR/Outpatient 3 1 Yes No 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot Certification Apr 10, 2009 1512 hrs 1 Yes 2 ✔ No Natural Pending To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4100 blk Nannie Helen Burroghs Avenue , NE Washing 3 Could not be Suicide determined (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number nature and title of certifier 29b. Si April 11, 2009 O.C.M.E.

⊗ √ State

OCME

Laron Locke MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

3 Registrar's Signar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Registra

within 24 hours after To the Funeral Dire To the Hospital

> 31. Date filed (Month, Day, Yea State Registrar

29b. Signature and title of certifie

Zabiullah Ali, M.D.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Sgnature ark

and manner stated

30. Name and address of person who completed cause of Beath (Item 23a)

May 9, 2009

29d. Date signed (Month, Day, Year)

29c. License number

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:30 P M 2009 Vertis Clella Clutts May 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brighton Gardens of Columbia Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 😿 F September 12,1914 Illinois 94 379-03-2320 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exarchast must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Jessup Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8641 Concord Drive 20794 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2 👿 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxxNo Specify. White 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other traumatic event, Italy Once. Department Store Sales Associate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aldolphus Kelley Iva Lasley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Duane Clutts (Son) 8641 Concord Drive Jessup, Maryland 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 🛣 Removal from State Sunset Hills Cemetery 5-15-2009 5 ☐ Other (Specify) Flint, MI 4 ☐ Donation Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin KNolls Road Columbia, Maryland 21045 21. Signature of Juneral Service License MU1283 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer 1.5 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last g physician and is the burial-tran-Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 No P.O. the 9 Unknown 9 ☐ Unknow signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 21X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D56531 May 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harry Li, M.D. 8600 Snowden River Parkway Suite 301 Columbia, MD 21045 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINIAL

			For State Registrar		State	of Mar	yland /		artment of F rtificate of I			ntal Hy	giene Reg. No	71111	9	15004
			Decedent's Name (First, M.	liddle, La	st)						2	. Date of De	eath		. T	3. Time of Death
	Physici /Medic		REBA CUS	ICK								Month	Da	7 20		00:04M
and in	Examin		4a. Facility Name (If not insti	ution, giv	e street and r	number)			4b. City, Town, o		of Death		40	c. County of De	ath	
			JOHNS HOPKINS (5. Social Security Number	6. S	EW MEDI	CALCI	ENTER (In yrs. last b	irthday)	BALTIMA If Under 1 Year		er 24 Hrs. 8	. Date of Bi	rth		Sirthnla	ice (State or Foreign
П	Funeral Director		246-30-6894		1 M 2			Yrs.	Months Days	Hours	Min.	(Month, D	av, Year,)	Counti	h Carolina
	7		Usual Residence of Deceder							1	1 1	P = ==	~ . , -		Į.	
	arylar show	<u>_</u>	10a. State 10b. Co				IOc. City, Tov	vn or Lo							10	d. Inside City Limits 1 □ Yes 2K No
	the M 28a-f	Directo	Maryland 10e. Street and Number	Bal	timore				I 10f. Zip Code	Dunda	ılk		10a C	itizen of What	Countr	
	aa or		7608 Cars	on A	venue				Tor. Zip Gode	2	21224			nited S		•
	death	Funeral	11. Marital Status		12. Was De	cedent Eve	er in U.S.	13.	Was Decedent of H f Yes, specify Cuba			fy Yes or No		14. Race - Ar	nerica	n Indian,
5-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Exarcinal remotified at	ξ	1 ☐ N <i>e</i> ver Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo			Forces? s 2 ½ ∏No Give Dates:		Ì	ryes, specily Cuba 1 ∐Yes 2 ∑t No	Specif		can, etc.)		Black, Wi Specify:		hite
2-0	72 ho	Completed	15. Dece (Specify only h	edent's Ed	ducation ade completes	d)	168	a. Deced	dent's Usual Occup	oation	est of warking		16b. h	Kind of Busines	ss/Indu	stry
2	nithin ne. han "	mple	Elementary/Secondary (0-			(1-4or 5+)		life. I	DO NOT use retired	d)	oc or working		_) t	4.	C+
D D	filed v Hygie ther t	ပ္ပိ	10 Years 17. Father's Name (First, Mic	Idle. Last)			Sa	les Clerl		her's Name (F	First. Middle		Departm n Surname)	ent	Store
an	ld be i ental ked o ic eve	To Be	William F.								nnie T			,		
Maryland 21	shou and M s mar		19a. Informant's Name/Rela						ng Address (Street							Code)
Z,	and 2 ealth a n 27 is		Mr. Michael A	• Cu	sick,	Sr.(S	on) 1	009	Byner Ro	oad	Essex,	Mary	land	2122	1	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exactinet must roughed at once.		20a. Method of Disposition M3bBurial 2 □ Cremat 4 □ Donation 5 □ Othe			m State	cemete	ery, cren	sition (Name of natory or other plac $11~{ m Mem}$. (Date 5/13/		}	ocation - City iddle R		
Balti	permit. Departr Importa any inju		21. Signature of Funeral Ser	vice Licer	nseg				Name and Addre							
			23a. Po 1. Enter the diseas	e or com	plications tha	t caused th	ne death. Do		7922 Wise er the mode of dyin					ryland		222 Approximate Interval Between
Ilia.	Physician		Immediate Cause (Final disease or condition	List only				ATHE	ROSCLERO	TIC (1	OCALA PI	ARTO	ev	DISEASE		Onset and Death YEARS
	/Medical		resulting in death)				consequence		TO SCHOKO	110 0	DA CHATTA	111010	, to 1	U I TENT		12MR
	Examiner	Ļ.	Sequentially list conditions		b										1	
	ted 1sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due t	o (or as a c	consequence	e ot):								
_,	execu n and al-trai	Examiner	that initiated events resulting in death) Last		c Due t	o (or as a c	consequence	of):							-	
98760	fficate be executed g physician and s the burial-transit	edical I		l	d											
_	ntifica ng ph	Medi	IF FEMALE:													
Box	death certifi e attending ed for use as	Physician/M	23b. Was decedent pregnan in the past 12 months?	1		e birth 2	☐ Fetal deat		Ectopic pregnanc	су				23d. Date of Month		y Day Year
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ∐ Pre 9 ∐ Un		me of death	5 [Other (specify) _					THO THE		, tou
т.	law requires that the das been signed by the		Part II. Other significant cor	ditions	contributing to	death but i	not resulting	in the ur	nderlying cause giv	en in Parl	t I.	23e. Did	tobacco	use contribute	to the	cause of death?
rds	quires n sigr uld be	d by										1 🗔	Yes 2	2 □ No 3 □	Proba	bly 4 Unknown
Vital Records,	law rec as bee 2 shou	pleted										24a. Was		24b. Were	autop	sy findings available
ž	The ate h	Comple					. .					auto perf 1 □ Yes	ormed?	death	?	pletion of cause of ⊇ □ No
ıta	ician: The lav certificate has rector, page 2	Be C	25. Was case referred to me examiner?	dical							ce of Death (1		
0	Physic this c		1 ☐ Yes 2 ☑ No		-	<u>`</u>			nt 3 DOA Oth	4 □ 1				6 ☐ Other (S	pecify,	
מ	dlng f h. After funer	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pe		(Mo	te of Injury onth, Day, Y		Time of Injury	Wor	ryat k?]Yes 2[d. Describe	how inju	ury occurred		
DIVISION	Atten death ctor: y the	ficat	3 ☐ Suicide 6 ☐ Co	estigation ould not be termined	e 28e. Pla	ce of Injury	- At home, f	arm, str	eet, factory, office	ITES ZL		. Location	(Street a	and Number or	Rural	Route Number,
2	al or a after	Certification: To	4 ☐ Homicide de	termineu	bui	lding, etc.	(Specify)					City or To	wn, Stat	te)		
	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, to	edical (miner: On the		xamination a		n occurred at the ti vestigation, in my o							
	vithir To th comp	Me	29b. Signature and title of ce	rtifier		,			29c. Licens	se number	7		29d. D	ate signed (Mo	nth, D	ay, Year)
			In the	2					RE	5-6	000		M	AY 7	20	09
	61		30. Name and address of per	son who	completed ca				Print)	, R	SALTIMO	ORE	MD	21224		
	Sta Registr		31. Date filed (Month, Day, Y				s Signature									
				-1-1-1	7666											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

			For State Registrar	Cer	tificate of I			Reg. No.	
a	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Andrew Joseph 4a. Facility Name (If not institution, give street an	Curreri	4h. City Town, or	r Location of Death	May	08 2009 4c. County of Deat	10 00
	Examin	er	20 Dunvale Road Apt. 508		**	Towson			timore
	Funeral Director		5. Social Security Number 6. Sex 11X M 2	7. Age (In yrs. last birthday) 94. Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day 09-19-19	91.4 Mary	thplace (State or Foreign Button) and
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	e 10c. City, Town or Loc	cation Towso	on			10d. Inside City Limits 1 ☐ Yes 2 🂢 No
		Funeral Director	10e. Street and Number 20 Dunvale Road Apt. 508	•	10f. Zip Code	21204		10g. Citizen of What Co U.S.A	١.
980	ours after deat iral", or items : Examiner mu	2	1 □ Never Married 2 ☑ Married 1 ☑ Year If Year	Yes 2 □ No s, Give or Dates: 1945–1946	l∐Yes 2∭X No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Specify:	white
21215-0036	rithin 72 h ne. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	eted) 16a. Deced (Give life. L Stock		eation during most of workir d)	ng	16b. Kind of Business.	•
	l be filed w ntal Hygie ed other t l event, th	Be	17. Father's Name (<i>First, Middle, Last</i>) Servio Curreri	3000	Nikari	18. Mother's Name Serefina			
Maryland	nd 2 should Ith and Me 27 is mark traumatio	ပို	19a. Informant's Name/Relationship (Type. Prin Mrs. Sara Lassiter - Daughte			and Number or Rura Joppa, Mar		er, City or Town, State, . 085	Zip Code)
Baltimore,	Pages 1 ar ent of Hea nt; If item 2 ry or other		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal 4 □ Dopation 5 □ Other (Specify)	from State 20b. Place of Dispo	sition (Name of matory or other place ley Mem. Go	ardens 05-1	ate 2-2009	20c. Location - City or Timonium, Man	·
Balti	permit. Departm Importar any inju		21. Signatury of Funeral Service Livensee	Le Le	onard J. R	ess of Facility uck, Inc.	5305 Har Baltimor	rford Road re, Maryland 2	21214
)	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):						Approximate Interval Between Onset and Death MonThS	
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequence of):				-5	
P.O. Box 68	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as to	Physician/Med	in the past 12 months?		∃Ectopic pregnanc] Other <i>(specify)</i> _	у		23d. Date of de Month	elivery Day Year
rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing	g to death but not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute t Yes 2	o the cause of death? robably 4 □Unknown
Division or Vital Records,	The lar ate has page 2	Completed					1□ Yes	psy prior to ormed? death? 2 No 1 □ Ye	utopsy findings available completion of cause of
ZI Z	Physician: this certificated director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatier	nt 3 🗆 DOA Ott	26. Place of Death		one dence 6 □Other (Sp	ecify)
n or	ng Phy fter this	on: To		Date of Injury (Month, Day Year) 28b. Time o	f 28c. Inju Wo	ry at rk?		how injury occurred	
ivisio	or Attending after death. Director: After in by the fune	Certification:	2 Accident Investigation	Place of injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No			Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Ce	(Check only 2 Medical Examiner: On	To the best of my knowledge, deat the basis of examination and/or in manner stated.	h occurred at the to	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mor	
			Foron (Sach	mo		061199		May. 8.	
	6 V		30. Name and address of person who complete	5 North Char	Print) 1-5 ST,	Su. 72 2c	19. To	owson Mi	21204
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Regetra's Signature	harle				

Physicia /Medic Examin

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar		_				
	1. Decedent's Name	e (First, Middle	e, Last)				
an al	Vi	rginia	W. (
er	4a. Facility Name (/	f not institution	n, give street				
	GREATER	BALTI	MORE M				
	5. Social Security N 219–10–86	608	6. Sex 1 □ M 2				
	Usual Residence of 10a. State	10b. County					
ral Director	Md.	Baltim	ore				
ire	10e. Street and Number						
ral	1055 W. Joppa Rd.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

15006 State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

	1 - State Registrar	,	Certificate of Deat		Reg. I	No.		
	Decedent's Name (First, Middle, Last)			2	. Date of Death	Day Year	3. Time of Death	
ın	Virginia W. Cro	rker		M	Month AY 0	6 2009	01:31 A ^M	
al er	4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location	on of Death		4c. County of Death		
	GREATER BALTIMORE MEDI	CAL CENTER	TOWSON			BALTIMORE		
	5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months Days Hour		B. Date of Birth (Month, Day, Yes	9. Birthp	lace (State or Foreign stry)	
	219-10-8608	89 Yrs	S.		April 26,	1920 Ma	ryland	
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			1	0d. Inside City Limits	
0	D 1.1	Towson					1 ☐ Yes 2 No	
rect	Md. Baltimore 10e. Street and Number	TOWSOIT	10f. Zip Code		10g.	0g. Citizen of What Country?		
	1055 W. Joppa Rd. #444	5	21204			USA		
era	11 Marital Status 12. Was Dec	edent Ever in U.S.	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Speci	ify Yes or No-	14. Race - Americ		
Ē	1 Never Married 2 Married 1 Tyes	2 ¬No			can, etc.)	Black, White,	etc.	
δ	3 ☐ Widowed 4 ☐ Divorced	ve ates:	1 □Yes 2 🙀 No Spec	ony:		Specify: Wh	ite	
sted	15. Decedent's Education (Specify only highest grade completed)	1 ((ecedent's Usual Occupation Give kind of work done during to	nost of working		. Kind of Business/Inc	dustry	
np(Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)			0 11		
Be Completed by Funeral Director	+	} Hom	nemaker 18 M	othor's Namo /	First, Middle, Maid	Own Home		
Be	17. Father's Name (First, Middle, Last)	T7 1				_		
ပ	William	Wooden	Aailing Address (Street and Nu	<u>Clizabet</u>		rris	(Code)	
	19a. Informant's Name/Relationship (Type. Print)							
	Mr. John M. Crocker/ Hust		055 W. Joppa R Disposition (Name of crematory or other place)	CO • #440 Dat	1 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	Location - City or To	wn, State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	State		F 0 00	, ,	11	3.4.1	
	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun	Druid R	idge Cemetery 22. Name and Address of Fa		<i>-</i>	ikesville	, Ma	
		\prec	Ruck Tows	son Fune	eral Home	, Inc.		
	23a. Part 1. Enter the disease, or complications that	caused the death. Do no	t enter the mode of dying, such	r Rd To h as cardiac or	owson, Mo respiratory arrest,	1. 21204	Approximate Interval Between	
	shock, or heart failure. List only one cause on Immediate Cause (Final	each line.					Onset and Death	
	disease or condition a.	(or as a consequence of)	•				497027	
	Pa	ba ble	mesenter	213	chen	119	71 hours	
Jer	Cognecticity list conditions							
Completed by Physician/Medical Examiner	ii any, leauing to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
Ä	resulting in death) Last Due to	(or as a consequence of)	:					
ical	d							
Med	IF FEMALE:						=======================================	
an/	23b. Was decedent pregnant 1 Live	itcome of pregnancy birth 2 ☐ Fetal death	3 Ectopic pregnancy			23d. Date of deliv Month	ery Day Year	
/sic	1 ☐ Yes 2 No 4 ☐ Pret 9 ☐ Unknown 9 ☐ Unk	gnant at time of death nown	5 Other (specify)					
P	Part II. Other significant conditions contributing to d	leath but not resulting in t	he underlying cause given in P	art I.	23e. Did tobac	co use contribute to t	he cause of death?	
β	Pulmonery em!	solven			1 ☐ Yes	2 No 3 Pro	bably 4 ☐ Unknown	
etec	Deep Vein thrombusis 24a. Was an 24b. Were							
ם		1 - 4			autopsy performed	prior to co death?	mpletion of cause of	
ပ္ပ	25. Was case referred to medical	-167 04	oe D	Ness of Dooth	1 ☐ Yes 2 (Check only one)	No 1 □Yes	2 🗆 No	
Be C	examiner?	Innationt 2 D FR/Outr	Othor			e 6 □Other (Speci	6/)	
ij	1 Yes 2 No							
atio	1 Natural 5 Pending (Mol 2 Accident investigation	nth, Day, Year) Inji	ury Work? M 1 ☐ Yes	2 □No				
iţic	опо	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or						
Cer	- I Torrioldo				,, 9	′		
Medical Certification: To	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the and mai	e best of my knowledge, basis of examination and nner stated.	death occurred at the time, day or investigation, in my opinion	te and place, a , death occurre	nd due to the caused at the time, date	se(s) and manner as and place, and due t	stated. to the cause(s)	
Me	29b. Signature and title of certifier		29c. License numb			Date signed (Month,	Day, Year)	
	+ William	onnen	MD 04	7/1	۹ /	Tay 6,	2009 Homme	
	30. Name and address of person who completed cau	se of death (Item 23a) (T	Type, Print) 6301	N. C	harles	SL Ba	Homere	

Registrar

31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. McLonzill Mr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per Dyr 98915/11/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 9, Physician 2009 11:17PM Drewry George /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Anne Arundel Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 02/10/1935 Birthplace (State or Foreign Country)
 TN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 411–56–8353 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, Ite Modical Examinat must be portfield at 1XYes 2 ☐ No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 2705 Yeomans Lantern Court 21401 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 💥 ☐ No Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5 + Wildlife Preservation Biologist 12 should be filed with and Mental Hygier 7 is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Patience Revnolds Earl Drewry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Heatth an Important: If item 27 is 1 any injury or other trau 1637 Judd Avenue, Wyoming, Michigan 49509 Steven Drewry, Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ※ Removal from State 05/12/09 Orlando, Florida Sunset Cremation 4 □ Donation 5 □ ther (Specify) 22. Name and Address of Facility Medcure, Inc. 21. Signature of Fu erall ervice Licensee T. Harman P.O. Box 55730, Portland, OR 97238 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner noumoul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ronsequence of) Exami burial-tran and Due to (or as a consequence of) Box 68760 attending physician certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day for Month Year 5 Other (specify) 2 No P.O. sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy No Union 2 1 ☐ Yes 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 \ Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 MA) 02 43371 30. Name and a wass of pers in who completed cause of death 4 m 23a) (Type, Print) Judy Joseph-Herbert,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 1 2009

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 4:03 PM Physician 2009 Devin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore niversity of Maryland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**∑** M 2□ F 25,1924 Maryland March_ Director 215-12-8626 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐XNo Director Anne Arundel <u>Glen Burnie</u> Maryland 10g. Citizen of What Country? 10e, Street and Number 21061 U.S.A 403 West Ordinance Road Apt 313 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2∭Wo Specify: Completed by 3

Widowed 4 □ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Clement Church N/A Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dettali Elizabeth ပ္ Joseph <u>DeVincent, Sr.</u> <u>Michael</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 Old Carriage Court Myrtle Beach S.C. 29588 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. Michael J. DeVincent, III (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5/13/09 Bayview Crematory 22. Name and Address of Facility 21. Signature of Fuperal Service Licensee McCully-Polyniak Funeral Home, P.A. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ediate Cause (Final List only one cause on each line. 21122 Approximate Interval Between Onset and Death Immediate Cause (Final Physician stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): requires that the death certificate be executed Exami and Due to (or as a consequence of): physician a s the burial-Box 68760, Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a o. ٥. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown has been signed by the property of the propert Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 ☐Yes 2 No certificate 1 ☐Yes 2 XNo : After this certification of the funeral director, I Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 📈 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Maryland MD 2000 D005915 611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Street Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

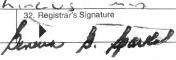
Registrar

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State Registrar

MAY 1 1 2009

31. Date filed (Month, Day, Year)



5310

			For State Registrar	State of Mai	-	Certificate			Reg. No	/11114	15010
	Physicia	an	1. Decedent's Name (First, Middle, La						Date of Death Month Da	y Year 7 7009	3. Time of Death
war.	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, T	own, or Location	of Death	lay 0	County of Deat	
m fri			University of Ma	ry land Med	lical Cent	er Bo	altimor			l o Pid	the land (Chate on Familia)
	Funeral Director			ex / 7. Age XIM 2□ F	(In yrs. last birt	Months Months	Days Hours	er 24 Hrs. 8. [Min. (Date of Birth Month, Day, Year) 5/18/19	9. Bin Co	thplace (State or Foreign buntry)
	land ow ■		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town						10d. Inside City Limits
	a-f sh	ctor	MD	N/A		Ba	ltimor	e City			1 XYes 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 126 W. Fort Av	enue		10f. Zip		1230	10g. Ci	tizen of What Co	usa USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hylgiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I're Medical Examiner must be notified at once.	þ	11. Marital Status ¹X∑Mever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 □Yes ¾√√No If Yes, Give Year or Dates:		13. Was Decede If Yes, speci 1 ☐ Yes 2	ent of Hispanic C ify Cuban, Mexica		Yes or No- n, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0	72 ho "natur	eted	15. Decedent's En (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usua (Give kind of work	k done during mo	st of working	16b. k	(ind of Business/	Industry
21215-0036	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT uso	house	Worker		Ship	ning
b	e filed al Hyg I other vent,	Be C	17. Father's Name (First, Middle, Last Samuel T. Ha	ddiy Tr	'	- 1112	18. Moti	her's Name (Fil	st, Middle, Maider	n Surname)	• 3
yla	d Meni marked matic	ပ္				Mailing Address	(Street and Num		ute Number, City		
N N	nd 2 sl alth an 27 is r sr traur		19a. Informant's Name/Relationship Evelyn L. Hadd	ix / Moth	er 1	435 Dec	atur S	treet,	Baltim	ore MD	21230
Baltimore, Maryland	Pages 1 a nent of Her int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Place of cemeter Loudo	Disposition (Nam y, crematory or ot n Park	e of her place) Cem Ma	ay 11,	2009 E	ocation - City or Baltimo	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	Victor	Doda	charle 1501 E	Address of Fact S L. S Fort	tevens Avenu	Funera e. Balt	l Home	Inc. MD 21230
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do r						Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a5	eptic	shoc	<u></u>				— — — — — — — — — — — — — — — — — — —
1	Examiner		1	Due to (or as a	consequence	ession	from	AML	ad Hi	V	
	pe iii	iner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):					
Q.	execute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):					
68760, 0	rtificate be executed ng physician and as the burial-transit	Medical E		d							
x 68	ertifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of	f prognancy					001.0	
O. Box	To the Hospital or Attending Physician: The law requires that the death cer within £24 hours after death. To the The The Theorem Signed by the attending to the Linearal Directors After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	Physician/li	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 4 Pregnant at 9 Unknown	2 🔲 Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp				23d. Date of de Month	Day Year
Vital Records, P.	ires that t signed by I be detac	ρ	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying ca	ause given in Par	t I.	23e. Did tobacco		o the cause of death?
COL	w requ	Completed			***				24a. Was an	24b. Were a	utopsy findings available
8	The la ate has	omo		<u> </u>					autopsy performed? 1 ☐ Yes 2 ☑ N	death?	
Vita	ician: pertifica ector, p	Be C	25. Was case referred to medical examiner?	Hospital:			26. Pla	ce of Death (C			
of	Phys er this eral dir	: To	1	28a. Date of Injur	y 28b.	tpatient 3 DO	8c. Injury at Work?		5 ☐ Residence Describe how inju		ecify)
<u>io</u>	ending ath. ir: Afte	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	njury M	Work? 1 □ Yes 2 [□No			
Division of	or Atter after de Directo	Certification: T	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		ry - At home, fa (Specify)	rm, street, factory	, office	28f.	Location (Street a City or Town, Sta	and Number or Fi te)	iural Route Number,
_	Hospita 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best o miner: On the basis of and manner stat	examination ar	e, death occurred ad/or investigation	at the time, date , in my opinion, d	and place, and leath occurred a	due to the cause at the time, date a	(s) and manner and place, and du	as stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier				. License numbe		29d. D	ate signed (Mon	ith, Day, Year)
			Inathan	- Darrin	n/ 1	•	15/95	755	Ma	y 07,	2009
	7		30. Name and address of person who	101	att/(Item 23a)	(Type, Print)	Balt	MACO	MO -	21231	
	Sta		31. Date filed (Month, Day, Year)	2. Registra	r's Signature	1-01	, 0011	11.10	1 111/2		·
	Registr	ar	頭ムT LLン()(M / Was And a	d. 4	BITTATURE .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 2009 RICHARD HOWARD 2:45 P M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE 30 FOXMOOR COURT OWINGS MILLS 8. Date of Birth (Month, Day, Year) 12/21/1953 Birthplace (State or Foreign Country) 6. Sex 1 M M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Min. Months Days Hours 55 ΙN 530-46-2775 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 2 No ANNE ARUNDEL MD DAVIDSONVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3506 VICTORIA LANE 21035 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 □Yes 2 No Specify: 3 Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CONSULTANT HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HOWARD ROBIN GROVES CLARENCE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3506 VICTORIA LANE, DAVIDSONVILLE, MD 21035 KATHLEEN EVANS / SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEM 05/15/2009 OWINGS MILLS, MD 4 ☐ Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funer Service Dc 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complicated shock, or heart failure. List only one can is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final 24000 disease or condition resulting in death) Due to (or as a consequence of) 2 years Supra ver if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) RESIDENCE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Physician

/Medical

Funeral Director

þ

Completed

Be

2

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "Medical Evancina" in at be notified at agines. Once.

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-transit Completed by Physician/Medical signed by the at the detached for ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2.8 Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

6 ☐ Could not be

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier Rough

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

10036242

29d. Date signed (Month, Day, Year) 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 Mitchells Chance Rd # 180, Edgewater. Lus mo home 97100 31. Date filed (Month, Day,

State Registrar

Medical

To the Hospital within 24 hours a To the Funeral C completely filled

Registrar
DHMH 17 Rev 1/2001

State

MD

RANDAUS

32. Registrar's Signature

HOSPITAL

31. Date filed (Month, Day, Year)

	For State Certificate	nt of Health and Mental Hygiene e of Death	Reg. No. 2009 1501
Physician/ lical Examiner	egistrar . Decedent's Name (First, Middle,Last) Frances Ray	James 2. Date of Month May 8,	2009 Year 1255 hrs
	la. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Baltimore County
i uniciai	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 1 M 2 XF 85	A II I I I I I I I I I I I I I I I I I	of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) North Carolina
w any	Usual Residence of Decedent 10a. State 10b. County Anne Arunde1 Manyland Daltimore 10c. City, Town or Severn Duna		10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	10e Ster a Bastille Road 2526 Mc Comas Avenue	21 144-1527 21 222-	10g. Citizen of What Country? USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she can whete other than "natural". To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 X No specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: White
2 hours after "natural", al Examiner eted by	15 Decedent's Education (Specify only highest grade completed) 16a, De	accedent's Usual Occupation (Give kind of work done uring most of working life. DO NOT use retired)	16b. Kind of Business/Industry
15-0036 Ried within 72 hour Hygiene. d other than "natu the Medical Exant the Completed	17. Father's Name (First, Middle, Last)	Vaitress 18.Mother's Name (First, Mic Etta Teagu	
t, MD 21215-003 and 2 should be filed within feath and Mental Hygene. trem 27 is marked other it fraumatic event, the Med	Kay Anderson Daughter 78	Mailing Address (Street and Number or Rural Rout 817 Bastille Road, Seven	e Number, City or Town, State, Zip Code) n, Maryland 21144
ages 1 and nt of Healt train other train		Disposition (Name of cemetery, ry or other place) of Faith Cemetery May 13, 200	20c. Location - City or Town, State Rosedale, Maryland
Baltin permit. P Departme Importan injury or	2) Signature of Juneral Service Licensee? 23a/Part I. Enter the disease, or complications that caused the death Do not	22. Name and Address of Facility Connectly Funeral Home 7110 Sollers Point Roa	d, Dundalk, Md. 21222
Physician / I dical)aminer	23a/Part I. Enter the disease or complications that caused the death Do not failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
executed an and al - transit	(Disease or injury that initiated events resulting in death). Last	5 105 con EU c902 7/22	700 TT
C e izi e	XUNPENDED X AMENDED 10B, 10C, 10C 23a, PII, 27 IF FEMALE: 23b. Was decedent pregnant in the 2	e& 10f, per FH g893 7/23, 28a-f, per ME g895 9/2/0	23d. Date of delivery Month Day Year
he death certificate the death certificate to the attending physiched for use as the buth sician/Me	past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown	Other (Specify)	. Did tobacco use contribute to the cause of death?
s, P.O. B nires that the d signed by the d be detached ed by Phy	Part II. Other significant conditions contributing to death but not resulting Hypertensive atherosclerotic ca	rdiovascular	Yes 2 No 3 Probably 4 ✔ Unknown Was an 24b. Were autopsy findings available
Records, I The law requires ficate has been sig , page 2 should be Completed	disease		autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No
Physician: The rhis certificate all director, page	1 Yes 2 No	26.Place of Death (Check only one utpatient 3 DOA Other Nursing Home	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that it toous after death. meral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detect Certification: To Be Completed by F	1 Natural 5 Pending Fd 5/8/09 Fd	1256 hrs 1 Yes 2 X No sub	ject fell
O fill bound	Suicide 6 Could not be 4 Homicide determined (Specify) residen	ath occurred at the time, date and place, and due to the	cation (Street and Number or Rural Route Number City Town, State) / 548 Old Telegraph Hanover, MD he cause(s) and manner as stated.
To the Howithin 24 h To the Funcompletely	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b Signature and title of certifier	nvestigation, in my opinion, death occurred at the tim 29c. License number	e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	May 9, 2009
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11 Penn Street, Baltimore, MD 21201	
Registral PHMH 17 Rev 1/2001		RIGINAL	OCMĘ

OCME 2006

WESTEN	E	1) WADLI) SEFFELSON	All Q A I	. 16.1
UNK UNK		Please Type or Print in Black Indelible Ink. Ensu State of Maryland / Department of Health at		gible.
		1- For State Registrar Certificate of Death		Reg. No. 2009 1501
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year 1005 have
Medical Examin			May 6, 20 or Location of Death	4c. County of Death
1)		1402 West Lafayette Avenue Baltimore		N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye $2/5-78-0/60$ 1 M $2/5$ F $4/8$ Yrs.	1 1 1 1 1 1 1 1	irth(MM/DD/YYYY) 9. Birthplace (State or Foreign South Country) Carolina
<u>*</u>		Usual Residence of Decedent 10a. State		10d. Inside City Limits
nd show as	٦	Maryland N/A Baltimore		1 X Yes 2 No
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 2/2		10g. Citizen of What Country? United State
// with 1	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of H	Hispanic Origin? (Specify Yes or Norm, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
ž 5 ≡ l	by Fun	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No 1 Yes 2 X No	No specify:	specify: Black
hours 'natur'	ted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	pation (Give kind of work done ife. DO NOT use retired)	16b. Kind of Business/Industry
136 thin 72 than than tedical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) None		None
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examities.	Be Con	17. Father's Name (First, Middle, Last) Willie Jefferson	18. Mother's Name (First, Middle,	· · · · · · · · · · · · · · · · · · ·
21; hould the nd Men is mar	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str	reet and Number or Rural Route Nu	mber, City or Town, State, Zip Code) BUTMITH, MD, 21229
Baltimore, MD ormit. Pages I and 2 sho Department of Health and Important: If item 27 is njury or other traumati		Lecia Jefferson-Little/Sister 3903 West N 20a. Method of Disposition (Name of a		20c. Location - City or Town, State
nore ages 1 at of Ha t: If it		1 Denial 2 Cremation 3 Removal from State crematory or other place)	Levy May 15	Lansdowne, Maryland
Baltin permit. Pa Departmet Importan				
inji ji ji		fern farle 270 Fredh	Iltm Pass Balt	Service, P.A. imere, Maryland 21229
Physician /Medical		23a. Part Enter he disease, or complications that caused the death. Do not enter the mode of dyir failure. List only one cause on each line.		rrest, shock, or heart Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) a. Acute alcohol intoxication and Due to (or as a consequence of):	and cocaine use	
	L	Sequentially list conditions, b.		
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
ed nsit	Exar	events resulting in death) Last Due to (or as a consequence of):		
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and innertal director, page 2 should be detached for use as the burial - transit	sician/Medical	X UNPENDED AMENDED 23a,27,28a-f,perME, §	g892 6/4/09 TT	
Box 68760, e death certificate be the attending physici ed for use as the buri	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
x 68 h certif tending use as	iciar	past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify)	2 Ectopic pregnancy	World Buy 1888.
Bo ne deat the at the dfor	Phys	1 Yes 2 No 9 Unknown g Unknown	as given in Bert I 23e Dir	tobacco use contribute to the cause of death?
tecords, P.O. Box The law requires that the death are has been signed by the atte	þ		g., a.,	'es 2 No 3 Probably 4 ✔ Unknown
ds, require been sig	Completed		24a. Wa	is an 24b. Were autopsy findings available prior to completion of cause of
ecor ne law i te has l	ldmo		per	formed? death?
al Re	o	25. Was case referred to medical 26.Pis	ace of Death (Check only one)	
Vita hysici this co	To B	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 Other: Scene
	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 1 Natural 5 Pending 28b. Time of Injury (Month, Day,Year)	Injury at Work? 28d. Describ	e how injury occurred
ision Attend er death rector:	ficati	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office	ce building, etc. 28f. Location	(Street and Number or Rural Route Number, City
Division spital or Atten hours after death meral Director;	Certification:	Suicide 6 X Could not be determined (Specify) unk	or Town	, State)UNK
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		, date and place, and due to the canion, death occurred at the time, da	ause(s) and manner as stated. te and place, and due to the cause(s)
Abh. EBES	Me		ense number	29d. Date signed (Month, Day, Year)
		(Continuent)	C.M.E.	May 7, 2009
		30. Hime and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Ba	lltimore, MD 21201	
St Regis	ate			
DHMH 17 Rev 1/2		OCME ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene

Physicia	ın
/Medic	al
Examin	er
Funeral	

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience Trust be neithed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

St Regist

	for State Registrar	Cer	tificate of Dea	th	Reg. No.	009 15015	
an	1. Decedent's Name (First, Middle, Last) SANDRA L.	KEENE		2. Da May	tte of Death	3. Time of Death	
eal ier	4a. Facility Name (If not institution, give street and number) 184 11th Street	KEITUS	4b. City, Town, or Locati Chelsea	ion of Death	4c. Cou	nty of Death	
		e (In yrs. last birthday) 67 Yrs.			tte of Birth conth, Day, Year) mber 21,1941	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent	07 113.		pace	inder 21,1941		
_	10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
ecto	Maryland Anne Arundel 10e. Street and Number	Chelsea	10f. Zip Code		10a. Citizen	of What Country?	
ral Dir	184 11th Street		21122		U.S.	Α.	
Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1	Vo	ar in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ⋈ No Specify: Specify:				
eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during I	most of working	16b. Kind of	Business/Industry	
omple	Elementary/Secondary (0-12) College (1-4or 5	life. D	lostess			aurant	
To Be	17. Father's Name (First, Middle, Last) John McClure		18. M		t, Middle, Maiden Surr enowith	name)	
	19a. Informant's Name/Relationship (Type. Print) Sharon A. Robbins (Daughter)		g Address (Street and Nu 4 1th Street,		te Number, City or Tot Maryland 2112		
	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem Cedar Hill	sition (Name of natory or other place) Cemetery	Date 05-11-09	1	on - City or Town, State n Park, Maryland	
	21. Signature of Funeral Service Licensee	end 32	CNATE and Address of F O4 Mountain Roa	Funeral Horad, Pasadena	ne P.A. a, Maryland 2	21122	
	23a. Part 1. Enter the disease, or complication, that caused lock, or heart failure. List only one cause on each li	ne.				Approximate Interval Between Onset and Death	
ŀ	mediate Cause (Final sease or condition a. Artev	rioselero	ic Hear	+ Dis	sease_	Onset and Death	
	Due to (or as						
iner	cause. Enter Underlying	a consequence of).					
Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
dical	d						
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		.05%		23d.	Date of delivery	
Completed by Physician/	in the past 12 months? 1		Ectopic pregnancy Other (specify)			Month Day Year	
d by Pr	Part II. Other significant conditions contributing to death by Reimer S Deme	iut not resulting in the un	nderlying cause given in F	Part I. 2	3e. Did tobacco use d	contribute to the cause of death? o 3 ☐ Probably 4 ☐ Unknown	
plete				2	24a. Was an 24	4b. Were autopsy findings available	
Com				1	performed? □Yes 2DNo	death? 1 □ Yes 2 ☑ No	
a	25. Was case referred to medical examiner?		Othor	Place of Death (Che	75. 2	Others (O	
유	27. Manner of Death 28a. Date of Inju	ury 28b. Time of	I S BOA 4L		5 Residence 6 Describe how injury oc		
catio	2 Accident investigation		M 1 ☐ Yes				
Sertifi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru City or Town, State)						
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or in	h occurred at the time, da vestigation, in my opinion	ate and place, and c n, death occurred at	iue to the cause(s) an the time, date and pla	d manner as stated. ace, and due to the cause(s)	
M	29b. Signature and title of certifier	Deputy	29c. License num	6054	29d. Date si	gned (Month, Day, Year)	
	30. Name and address of person who completed cause of a	death (Item 23a) (Type,	Print)	rerica	2103	35	
ate		rar's Signature	1	, , , , , , , , , , , , , , , , , , , ,			
rar	MAY 1 1 2009 Seneral	A. Marke			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Month 12:56 AM may Kenneth A. Kleiber 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore 21204 Genesis Multimedical Center 7700 York Road Maryland TOWSON 9. Birthplace (State or Foreign If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, May 12. 5. Social Security Number 7. Age (In yrs. last birthday) Days Pennsylvania 1 ☐ M 2 ☐ F 79 217-22-0609 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 🙀 No Lutherville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21093 7 Croftley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Automotive Technician

16b. Kind of Business/Industry

Automobile

Watson

18. Mother's Name (First, Middle, Maiden Surname)

Frances

7 Croftley Rd., Lutherville, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other traumetic event. It is Moulfall Examinational Language. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

Elementary/Secondary (0-12)

Adam

12

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Frances C. Kleiber-wife

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Kleiber

Completed by Funeral Director

To Be

Funeral

Director

Priysician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	cemetery	Disposition (Name of y, crematory or other place) ey Valley		oc. Location - City o Timonium,			
	21. Signature of Funeral Service License	⇔William G. Dau		Ruck Towson, Towson, MD	Funeral 21204	Home, Inc.		
al Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the total of the consequence of the con	on: s Mellitus (ur on:			Approximate Interval Between Onset and Death 5/7/09 LOYS Vears		
nysician/medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date 1 Live birth 2 Fetal death 3 Ectopic pregnancy 3c. If yes, outcome of pregnancy 23d. Date 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 5 Other (sp							
Dy P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribution of the underlying cause given in Part I. 23e. Did tobacco use contribution of the underlying cause given in Part I. 23e. Did tobacco use contribution of the underlying cause given in Part I.							
Completed	Dysphagia for m			24a. Was ar autops) perform 1 ☐ Yes 2	red? death?	autopsy findings availat completion of cause o ? es 2 \(\square\) No		
Be	25. Was case referred to medical		26.	Place of Death (Check only one)			
0	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient 3 DOA Other: 4	ursing Home 5 ☐ Reside	nce 6 □Other (Sp	pecify)		
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ime of pjury at Work? M 1 Yes	28d. Describe ho				
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)				
edicai C		isian. To the best of my knowledge ner: On the basis of examination and and manner stated.						
Me	29b. Signature and title of certifier		29c. License nun	nber 29	d. Date signed (Mo	nth, Day, Year)		
	Muchelle G. K.	alendels CRUP	R09	7104	5/8/20	009		

State Registrar

within 24 hours a

Michelle E. Kalendek CRNP Genesis multimedical Center 7700 York food Towson, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

TMRAN 31. Date filed (Month, Day, Year)

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32 Registrar's Signature

DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 Ma 6 nard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltim ore Bayview Medical Johns Hopkins 8. Date of Birth (Month, Day, April 7, 9. Birthplace (State or Foreign Country)
Maryland If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 212-50-4200 61 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location show or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21222 7304 Dunlawn Court Apt B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 P, 1 ☐ Yes 2 🛣 No Specify. Specify: White event, the Medical Exa-Completed by 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Security 7 years Guard 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental Hvo 17. Father's Name (First, Middle, Last) Be Dorothy Parker Vernon Lindsay traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a 7304 Dunlawn Court Apt B, Dundalk, Maryland 21222 permit. Pages 1 an.
Department of Heatt.
Important: If item 27
any injury or other tra Sharon A. Lindsay wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) May 11, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2009 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P 7110 Sollers Point Road, Dundalk, 21. Signature of Funeral Service Licensee 21 222 23a. Part 1. Enter the disease for complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final 5 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) P.0. the 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Months Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this funeral c 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Hospital or Attending 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signatu

30. Name at

31. Date filed

PEDERIC

1 1 2009

Year

(Month, Day,

4940

rson who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Si

IN

29c. License number

EASTERN AVENUE

20040642

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 300 A M Clifford Peter Laforme /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Laurel Laurel Regional Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, March 24, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F 007-12-3873 86 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 No Director Columbia Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21046 USA Funeral 9652 Sandlight Ct. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐Yes 2 No Specify: þ White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hand Sewer Shoe Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Dore Charles Laforme ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9652 Sandlight Ct., Columbia, MD 21046 David Laforme- son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State May 7, 2009 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, INC. MO(25 7601 Sandy Spring Rd., Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of) Disease Coronary Artery Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specity) 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🕅 Natural 5 Pending investigation

Examiner law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records,

burial-transit attending physician the nse for 1 the has certificate

Funeral

Director

28a-f show

ō 23a

"natural", or items

than

ermit. Pages 1 and 2 should be filed wi lepartment of Health and Mental Hygien nportant: If item 27 is marked other th.

permit. Pages 1 Department of H Important: If iten any Injury or otl

Physician

/Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner nest be notified at

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

Medical

State Registrar 29b. Signature and title of certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

22966

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

7300 Van Dusen

1 □Yes 2 □No

Laurel, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause oldeath (Item 23a) (Type, Print) Laurel Thomas

6 ☐ Could not be

Regional Hospital Emergency Dept.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 7, ^{Day} 2009 10:15 PM **Physician** Elsie Marie Mangers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda 4804 Newport Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Aug 22, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months Hours Massachusetts 87 1921 022-18-5414 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modest Evancines in ust be notified at 1 X Yes 2 □ No Director NC Pinehurst Moore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 15 E. McDonald Road 20374 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2★ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2X If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣No Specify: White ð 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Health and Mental Hygiene. Elementary/Secondary (0-12) Retail Store Fashion Coordinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) be Beatrice DeRobertis Joseph Barone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4804 Newport Avenue Bethesda, MD 20816 Ralph Graham Neas/son item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State W. Arundel Crematory: 05/09/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Coing homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pancreatic Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Year in the past 12 months? 1 □ Yes 2 ☑ No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate spital or Attending Physician; Thours after death.
Ineral Director; After this certifical y filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be 1∐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

and title of partifie

29b. Signatur

Matthew

32: Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McAndrew, M.D.

29c. License number

110 Irving St NW Washington, D.C. 20010

29d. Date signed (Month, Day, Year)

May 8, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e-f, 20a&20c, 22, per Fh g891 5/11/09 TT

State of Maryland / Department of Health and Mental Hygiene

1- State AMEND ITEM#20b,c,perFH,g893,7/16/09WSrtificate of Death

Reg. No. 2 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:00A 2009 Ella B. Miller Mai /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Sina Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 1, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months 1 □ M 2 🛛 F Vrs Virginia 220-20-6794 83 1926 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Midical Examiner must be notified at MD Baltimore 1▼ Yes 2 No Director 28a-f 10e. Street and Number 2908 Garrison Blvd. Apt 1A 10f. Zip Code 21216 10g. Citizen of What Country? marked other than "natural", or items 23a or 4814 Laurel Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. claims supervisor goverment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked of James Sinclaire Miller Matilda Marie Saunders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Desiree Hudson/niece 2908 Garrison Blvd #1A Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD

22. Name and Address of Facility Joseph L. Russ F.H. 2222 W. North Greenmount Crematory 6/29/09 4 □ Donation 5 N Other (Specify) in state 21. Sign, ture of Funeral S S. Wade 'n Baltimore Street Ave. 1xxx Baltimore, MD 21201 21216 mi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Final disease or condition resulting in death) gashowteshow **Physician** /Medical Due to (or as a consequence of) **Examiner** The Illahon Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner physician and the burial-transit Congestive Due to (or as a consequence of): Box 68760. death certificate be Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) ed by the a detached f P.O. 9□Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, by Chronic 1 Yes 3 No 3 Probably 4 Unknown Obsmidwe anna page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed Hyperlipidemia 1∐ Yes 21 No Physician: ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Hospital 20 No within 24 hours after death.

To the Funeral Director: After this of the Funeral Director After this of the Funeral directors. Inpatient P Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 1, 2009 M MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Gupla 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day -Month 5:25 A. 7 2009 Julia May Moore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death San Jose Group Home Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept.14, 1913 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛱 F Months Days Hours Min Pennsylvania 373-01-5704 95 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes XX No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6035-1 Majors Lane 21045 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 XX If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Sales Bakerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gabney (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline F. Moore (Daughter) 9414 Merryrest Road Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 5-12-2007 Elkridge, Maryland 21. Signature of Funeral Service Lio-22. Name and Address of Eacility Witzke Funeral Homes, Inc. 5555 Twin KNolls Road Columbia, Maryland 21045 200 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mmediate MOCEYO disease or condition resulting in death) Due to (or as a consequence of): cars if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner** The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

show

Director

Funeral

<u></u>

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once.

3altimore, Maryland 21215-0036

the Maryland

/Medical

burial-transi and attending physician for use as the buria signed by the atten d be detached for u peen page 2 s has within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page To the Hospital or Attending Physician: 'within 24 hours after death.'

To the Funeral Director: After this certifica

P.O. Box 68760

Division of Vital Records,

Examine Physician/Medical þ Completed Be မ Certification:

9 Unknown 1 ☐ Yes

29a. Certifier

Medical

State Registrar 25. Was case referred to medical examiner?

27. Manner of Death 5 Pending investigation 2 Accident 6 ☐ Could not be

3 ☐ Suicide determined 4 ☐ Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hall Drive Ellicott City Maryl

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Eversley Dorsey

31. Date filed (Month, Day, Year)

29b. Signature and title of contif

Registrar's Signature

and manner stated.

09-036	28
Kaitlyn	McClung

aitlyn McClung		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1502
Physiciar Medical Examin	n/	Registrar 1. Decedent's Name (First, Middle, Last) Kaitlyn Marie McClung 2. Date of Death Month Day Year May 6, 2009 1448 hrs
,		4a. Facility Name (if not institution, give street and number) Sinai Hospital 4b. City, Town, or Location of Death Baltimore
Funeral Director		5. Social Security Number 217-83-1004 6. Sex 1 Months Days Hours Min. Dec 3 2008 7. Age (In yrs. last birthday) 1 Months Days S Hours Min. Dec 3 2008 7. Age (In yrs. last birthday) 1 Months Days S Hours Min. Dec 3 2008 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
yland -f show any .once.	ţ.	Usual Residence of Decedent 10a. State
with the Maryland us 23a or 28a-f sho be notified at once.	Director	2103 Spencer Lane 21048 USA
r death	by Funeral	11. Marital Status 1
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours aften or of Health and Mental Hygiene Innet of Health and Mental Hygiene Innet: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) O 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) never worked 16b. Kind of Business/Industry
e filed wi	Be Co	17. Father's Name (First, Middle, Last) Terry Dean McClung Jr. Stephanie Lynn Meyer
ID 21; should b and Men 7 is marl		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Dean McClung Jr.(father) 2103 Spencer Ln., Finksburg, MD 21048
Baltimore, M Permit Pages I and 2 Department of Health Important: If item 2 Injury or other traus		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State All County Cremation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation 5 Sykesville, MD
Baltimore permit. Pages I Department of F Important: If injury or other		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784
Physician /Medical :aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden unexplained death in infancy (SUDI) Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.
d sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
execu an and	dical	X UNPENDED 23a,27,28a-f,perME, g893 7/7/09 TT
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	≗i	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
, P.O. B	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, Figures rate death. 12 Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Recician: The	Be	25. Was case referred to medical examiner? Hospital: 4. Inspiral: 3. FD/Outseliest 3. DOA Other, Nursing Hope 5. Residence 6. Other
ion of Vi tending Physi eath. ior: After this the funeral dir	ation: To	27. Manner of Death Natural 5 Pending Investigation Pt 5/6/09 Pt 1:10 pm 28c. Injury at Work? 1 Natural 5 Pending Investigation Investigatio
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 X Could not be determined Specify Specify Specify See. Place of Injury - At home, farm, street, factory, office building, etc. Specify See. Place of Injury - At home, farm, street, factory, office building, etc. Specify See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home, farm, street, factory, office building, etc. See. Place of Injury - At home
To the Hospital within 24 hours To the Funeral completely filled	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Me	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) May 8, 2009
7		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature
DHMH 17 Rev 1/200	_	ORIGINAL OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month RMA Mirvis **Physician** /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner illuindale Geriatic Conter Jaly 1 more 8. Date of Birth (Month, Day, Year) 07/28/1925 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🗓 F MD 83 213-20-3240 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No BALTIMORE OWINGS MILLS Directo MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number o e USA 21117 "natural", or items 23a sdical Examiner must b 2318 CAVESDALE ROAD Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23.
ary or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRIEDLANDER FANNIE P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2318 CAVESDALE ROAD, OWINGS MILLS, MD HOWARD MIRVIS / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important; If itel
any Injury or otl 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 05/08/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.
neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) R070440 C5104/20029b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

MOSSE CRNP, 24

32. Registrar's Signature

34W. Belvedere Aug Baltimore

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** OSTEEN 6, May 2009 GARFIELD 10:48am DAVID /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Shady Grove Adventist Hospital Rockville Montgomery

9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace Country) **Funeral** 1 M 2 □ F Months Days Hours Min. 251-10-8226 90 1919 NC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examiner must be notified at Yes 2□No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 19904 Chesley Knoll Drive 20879 USA 12. Was Decedent Ever in U.S.

Armed Forces?

★★★ 2 □ No Coast
If Yes, Give Guard
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. The street of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: à 3 Widowed 4 Divorced 40 - 45Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Insurance 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. O'steen Ludith Ledbetter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Emma O'steen / Wife 19904 Chesley Knoll Drive, Gaithersburg MD 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakeview Mem. Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State 5/11/09 Greensboro, NC 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Charles L Stevens Funeral Home
1501 E. Fort Avenue, Baltimore wice Licensee Victor Doda Home, Inc. imore MD 21230 Via Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute myocardial minux disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rtheroscieration Samulative State of the state o Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed a 24 hours after death.

24 hours after death.

25 Horneral Director: After this certificate has been signed by the attending physician and lelely illed in by the Internetal director, page 2 should be detached for use as the burtal-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 □ Yes 2 □ 1√0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hos within 24 ho To the Fund completely is (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D002807-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Center Prive, Ruckville, Md. 20850 Medical Wenk State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9, Proctor May 2009 Norman Wayne 20:07P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 7795 Peninsula Expressway Apt 210 Dundalk 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** September 13,1944 Months Days Hours **1**∤ΩM 2□F 236-64-8657 64 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural any injury or other traumatin many injury or other many o 7795 Peninsula Expressway USA Apt 210 21222 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tile Brick Layer Shipping 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Whitacre Charles H. Proctor ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sonja Walters Daughter 1008 Old North Point Road, Baltimore,Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 11, Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Maryland 21222 Signature of Fungral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alcohol Abuse disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Liver Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Chronic Kidney Disease attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, COPD Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hacel to ME ivision of Vital Records, Be Completed by hx GI bleed, depression 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Discompletely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier

State Registrar

(Month, Day, Year)
MAY 1 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hayasis IME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:45 P M May 6, 2009 Henrietta C. Pessaro /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Co. Dunda1k Genesis Heritage Meridian Nursing Home Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
June 17,1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 83 219-18-7209 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TX No Director Baltimore Co. Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 0 21224 United States 7204 Fait Avenue items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 ò 1 □Yes 2XINo Specify Specify: þ 3 X Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 72 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Naja Henry Crist ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 is rr any injury or other traum once. 21206 7110 Greenwood Ave. Baltimore, Maryland Mr. Charles F. Pessaro, Jr. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/12/2009 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 >PG 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): RIGHT PLEURAL EFFUSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner OBSTRUCTIVE PULMONARY DISEASE The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. | cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No certificate 1 ☐Yes 2 No Hospital or Attending Physician; 25. Was case referred to medica examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 0 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 1 atural 5 Pending n 24 hours after death.

The Funeral Director: After the further than 10 to 10 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 C ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ICTULICE MD of death (Item 23a) (Type, Print)

14 2 Manked-Place Dundalic MD 2/222 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAY LEONARD PONDFIELD 11:40 P M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE TOWSON BALTIMORE 6. Sex 1 **X** M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/11/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 218-26-8517 79 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examination as be retified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 SLADE AVENUE, #222 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 □ No ARMY If Yes, Give Year or Dates: KOREA 2 □ No ARMY 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR PONDFIELD'S CLOTHES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEN PONDFIELD 2 MINNIE ROTHSTEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL PONDFIELD / WIFE 7 SLADE AVENUE, #222, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State SHAAREI ZION 05/08/2009 ◆☐ Sonation 5 ☐ Other (Specify) ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1 Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) danon Physician 1 Tars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) MINIC 1 ☐ Yes 2 🗀 🚜 🔾 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

			For State	State of Ma	aryland		irtmen <i>tificat</i>			d Menta	al Hygie Reg.	6-	009	15029
	_		Registrar 1. Decedent's Name (First, Middle, Last)								e of Death			3. Time of Death
	Physicia		Patricia Ann Ta	art Reav	res					May	_	Day 2009	Year)	0205 M
-	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location of D			4c. Cour	nty of Death	10200
	Examin	er	Joseph Richey Ho				Ва	ltin	nore			N	'Α	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. la:	st birthday)	If Under	1 Year Days	If Under 24	Hrs. 8. Dat	te of Birth onth, Day, Ye	ar)	9. Birth	place (State or Foreign
	Director		051-38-0521	M 2□xF	64	Yrs.	WOTHING	Dayo		Jul	Ly 29	, 19		.Carolina
	D >		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation	_						I Od. Inside City Limits
	sho	'n			Too. Only,				_					1, Yes 2 No
	the M	ect	Maryland N/A			В	alti 10f. Zir		=		10g.	Citizen	of What Cou	ntry?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show diesi Evantinus be undfisd at	by Funeral Director	1732 Poplar Gro	va Stra	at			212	16			USZ	A	
	ns 23	era		12. Was Decedent		. 13.1	Was Dece		ispanic Origin n, Mexican, P	? (Specify Ye	s or No-		Race - Ameri	
' C	fter d r iten	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ I	No					uerto Rican,	etc.)		Black, White,	etc. ack
036	urs a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □Yes	2 LJK40	Specify:			Spe	city: Þ.L	ack
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)		16a. Dece	dent's Usu kind of wo	al Occup	ation during most of	working	161	o. Kind of	Business/Ir	ndustry
7	within iene. than "	dr.	Elementary/Secondary (0-12)	College (1-4or 5	5+)			se retired	luring most of ()		C :	1 0 -	ala D	akery
2	filed w Hygier other the	ဒ	10th grade			Bake	r		19 Mothor's	Name (First,				akery
anc	be fi	Be	17. Father's Name (First, Middle, Last)						Peco.	_	maare, ma			
Ĕ	hould of Me mark matic	우	John F. Tart 19a. Informant's Name/Relationship (Ty	ne Print)		19h Mailis	na Address	s (Street	and Number o		e Number. C	ity or To	wn, State, Zi	p Code) 2121
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Medical Experiment to conflike at a		Maxine Reaves/		r	2936	W.	Col	dspri	ng Lai	ne Ap	t.	E. _{Bal}	timore, Mo
φ	t and Health tem 27		20a. Method of Disposition		20h Pla	ace of Dispo metery, crei	sition (Na	me of	100	Date	20	c. Location	on - City or T	own, State
Baltimore,	permit. Pages Department of Important: If Its any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Mt	. Zic	n Ce	emet	ery 5,	/16/0				Maryland
<u>≡</u>	mit. F partm portar injui		21. Signature of Funeral Service Licens	9		22	2. Name a	nd Addre	ss of Facility	Chatm	an-Ha	rri	s Fur	eral Nom
m	Depar Impor any Ir	V 9	Kerow Al	irris		4 5	240	Rei	sters	town :	Rd Ba	lti	more,	Md 21215
		6	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	ications that caused	d the death.	Do not en	ter the mo	de of dyir	^					Approximate Interval Between
	Physician	-	Immediate Cause Final disease or condition	Newsa		deno	Cerci	northa	Part I	the	color	7	1	Onset and Death
	/Medical	ш	resulting in death)	Due to (or as										7
	Examiner	l. I	Sequentially list conditions,),										
K.	sit ed	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of).								
20	xecut and Il-tran	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
68760, ² / ₂	cate be executed physician and the burial-transit	ם				,								
387	ficate phys s the	edical		J. ,								1		
Box (death certifi e attending I d for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7					23d.	Date of deli	very
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth			☐ Ectopic ☐ Other (s		У				Month	Day Year
P.0	at the de by the tached	Physician/M	9 Unknown	9 🗌 Unknown					_					
S, F	g 99	by P	Part II. Other significant conditions co	ntributing to death t	out not resul	Iting in the u	inderlying	cause giv	en in Part I.	23				the cause of death?
ord	w requires t s been signe should be		Malnut	11 2M						-	1 🗌 Yes	2 🗆 N	o 3∐ Pro	bably 4 🗍 Unknowr
Record	aw Isb	Completed								24	4a. Was an autopsy		prior to c	topsy findings available ompletion of cause of
- H	The ate h page	Ö								1	performe □Yes 2		death? 1 ☐ Yes	2 🗆 No
Vital	Physiclan: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	1 2.1				100		f Death (Che	ck only one)			
of \	ys dir	မ	To res ZENO		ient 2 🗆 E	<u>`</u>			4 LI Nursi	ing Home 5				city) MOSPICE
	ling After funer	io :	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		28b. Time o Injury	M	28c. Inju	ryat k? Yes 2.∐No		escribe how	injury oc	curreu	
Sic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	iury - At hor	me farm st			162 2		ocation (Stre	et and N	umber or Ru	ral Route Number,
Division	f or Attend after death Director:	Certification:	4 ☐ Homicide determined	building, e	c. (Specify)	1001, 10010	7, 011100			ity or Town,			,
	To the Hospital or within 24 hours after To the Funeral Directory completely filled in the filled in		29a. Certifier 1 Certifying Phy	sician: To the best	t of my knov	vledge, dea	th occurre	d at the t	me, date and	place, and di	ue to the cau	ıse(s) an	d manner as	stated.
	e Ho: 124 h e Fur	Medical	(Check only one) 2. Medical Exam	iner: On the basis and manner s	of examinat	ion and/or i	nvestigatio	n, in my	opinion, death	occurred at 1	the time, dat	e and pla	ice, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				25	c. Licens	se number		290	l. Date si	gned (Month	n, Day, Year)

Bal hour, mo

29b. Signature ar

29c. License number 056211

Haneve St.

29d. Date signed (Month, Day, Year)

3001 31. Date filed (Month, Day, Year) RAY 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

5000

PATRICIA REAVES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3_ April 2009 1:41 Marcella Elizabeth Rowe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year)

June 27,1940 If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 □ M 2**X**) F Wash 68 June Director 578-56-4349 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Modical Examinations to notified at 1X Yes 2 No Director Howard MD Laurel 10g. Citizen of What Country? 10e. Street and Number death with USA 20723 10095 Washington Blvd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Food Service Worker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be Lillian Malone ပ Clarence Rowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10095 Washington Blvd. Laurel, MD Health a Nakia Abrams/Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any Injury or oth once. 1 Burial 2 □ Cremation 3 □ Removal from State 4/22/09 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Austin 22. Name and Address of Facility AUstin Royster FUneral Home Signature of Funeral Service License 3821 14th Street, NW, Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate C := 6 (Final disease or condition resulting in death)

a. Hypoxic Respiratory Failure

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and ss the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 □ Yes 2 X No 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 9 🗍 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Renal Failure autopsy performed? Yes 2 2000 1 ☐ Yes 2 No Atrial Fibrillation 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director; A
bletely filled in by the fu 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 13, 2009 D68150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 Nejib Siraj, MD 1500 Forest Glen Road, SIlver Spring, MD 32 Registrar's Signatur State Kenna Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) 2009 Month :40 A.M. **Physician LYNN** ROSS DTANE 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore County **ESSEX** JUDYWOOD LANE 8. Date of Birth (Month, Day, August 29 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year) Months Days Hours 1 □ M 2 ■ F Maryland 1948 60 Director 212-52-2835 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No **Baltimore** Essex Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number be filed within 72 hours after death with Intal Hygiene. U.S.A. 21221 Judywood Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Homemaker Housewife \cap 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McAlexander Bettv Ann Ear1 Milton Henry ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum once. 117 Judywood Lane, Baltimore, Maryland 21221 Alpheus Daniel Ross (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State May 11, 2009 Baltimore, Maryland Bayview / Crematory 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility *Coulty-Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 21. Signature of Funeral Service Licenses Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final 10 mondies mediate Cause (r disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnent et time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacço use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 12 No certificate 1 ☐Yes 2 DNo 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2.

State Registrar 31. Date filed (Month, Day, Year) 1 1 2009

min (th. v)

29b. Signature and title of certifier

39 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 32. Registrar's Signature

29c. License number

208

29d. Date signed (Month, Day, Year)

MD 2123-

1. Decedent's Name (First, Middle, Last)	Reg. No. 2009 15032									
Dhysician	2. Date of Death Month Apay Apay									
Physician /Medical Joanne Stella Rombouts 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death										
4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death	on Baltimore									
Funeral Director 5. Social Security Number 364-26-7093 6. Sex 1 Months 2 Min. 7. Age (In yrs. last birthday) Months 1 Months 1 Min. 1 Months 1 Min. 1 M	8. Date of Birth (Month, Day, Year) Aug 1, 1924 9. Birthplace (State or Foreign Country) Michigan									
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
Baltimore Owings Mills	1 □Yes 2√√ No									
MD Baltimore Owings Mills MD Baltimore Owings Mills	10g. Citizen of What Country?									
405 Garrison Forest Road 21117 11. Marital Status 1 Never Married 2 Married										
10a. State 10b. County 10c. City, Town or Location 10d. Zip Code 10f. Zip Code 10f	Pricán, etc.) Black, White, etc. Specify: White									
1	16b. Kind of Business/Industry									
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work (ilite. Do NOT use retired) 17	Own home									
18. Mother's Name (First, Middle, Last)	ne (First, Middle, Maiden Surname)									
D USE I TO SEE THE SEA OF SEA	anna Popko ral Route Number, City or Town, State, Zip Code)									
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru 405 Garrison Forest R	d., Owings Mills, MD 21117									
20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State									
1 Burial 2 Oxcremation 3 Removal from State 4 Donation 5 Other (Specify) 11 Burial 2 Oxcremation 3 Removal from State 4 Donation 5 Other (Specify) 121. Signature of Funeral Service Insee William G. Dau 1 Dec York Pd. To	11/09 Towson, MD									
1000 101 K Na. 3 10										
shock, or heart failure. List only one cause on each line.										
Physician /Medical Immediate Cause (Final disease or condition resulting in death) ACUTE FERITONITIS Due to (or as a consequence of):										
Examiner INTESTINAL PERFORATION b.										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ADVANCED ATHEROSCLEROTIC CAI Due to (or as a consequence of):	RDIOVASCULAR DIS									
Cause, Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last										
physician the burial dical E										
	23d. Date of delivery									
in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown U	Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown									
he law requires the law requires the law speen signe age 2 should be completed by complete co	24a Was an 24b. Were autopsy findings available									
Ø 6 8 0 Q	autopsy prior to completion of cause of death? 1 □Yes 2 No 1 □Yes 2 □No									
Use the second of the second o	ath (Check only one)									
Ψ α ξ o 1 Yes 2 No 1 Mongatient 2 ER/Outpatient 3 DOA Strict 4 Nursing i	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred									
This same of the s										
This same of the s										
This same of the s	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
The second state of the se	e, and due to the cause(s) and manner as stated.									
28c. Injury of the light of t	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)									
The state of the s	city or Town, State) le, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) May 7, 2009									
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 28	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)									

DHMH 17 Rev 1/2001

P.O. Box 68760 Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENDIE BWTW 283 Smith Avenus Baltimore MD 21209 5 W 31. Date filed (Month, Day, Year) State MAY 1 1 2009 Registrar **ORIGINAL**

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Sulvia 8=59AM Schelhause 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) medical center Battimore University of Maryland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Numb 6 Sex Hours Min Months Days 212-34-7458 1 M 3 TX 72 12/7/ MD Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 □ No N/ABaltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 600 Light STreet, Apt 511 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 24 TWNo Specify White If Yes, Give Year or Dates: Specify. 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Factory Worker Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca F. Smithers Charles Crew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) /Daughter 4037 6th Street, Brooklyn MD 21225 Gina M. Schelhause 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 5/8/2009 Hanover Maryland Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home, ∀ictor Doda 1501 E. Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. decompensated Heart. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 7 olcu piratory ailus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown Acrili Stenosis se vere 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed, Vasceller 2 ☐ No 1 ☐ Yes 2 MNo 1 🗌 Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

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Funeral

Director

ral", or items 23a or 28a-f show Examiner must be rediffed at

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, In Magnesia.

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Hospital or Attending Physlcian: The law requires that the death certificate be executed the attending physician and cate has been signed by the page 2 should be detached ours after death.

eral Director: After this certific filled in by the funeral director, I

Division of Vital Records, P.O. Box 68760

Examine Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by congestive Heart failure, Plever oe it 25. Was case referred to medical examiner? Be examiner? 1 Yes 2 ∏ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Inju Wor 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check Only One)											
			6 ☐ Other (Specify)								
ry at k?	28d.	Describe how inju	ury occurred								

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

	/					
29b.	Signature	and	title	of	certifier	
		-070	/			

3 Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be

determined

29c. License number ID218228 29d. Date signed (Month, Day, Year) 5/6/2009

MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, MD2/201 ingyi Clas, 22 Greeke st

State Registrar

Medical

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completely To the within 2

			For	State of Maryland				nd Mental H	ygiene	0.00	0 15005
			State Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate c	of Death	2. Date of D	Reg. No	200	9 5 0 3 5 3. Time of Death
	Physicia		Mary J. Sneed					Month April	Da	2009 Yea	
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Towr	n, or Location of			County of De	eath
-			6229 Auth Road	1= -			tland	4 Hrs. Lo. D. L 4 D			Georges
	Funeral Director		5. Social Security Number 417-24-7026 6. Sex 1□	M 2 DXF 7. Age (In yrs. In 89	ast birthday) Yrs.	If Under 1 Ye Months Da		Min (Month, L	31 , 1		Birthplace (State or Foreign Country) Labama
	ס		Usual Residence of Decedent					nug.	J = 1 =		
	arylar show	'n	10a. State 10b. County		, Town or Lo						10d. Inside City Limits 1XYes 2 □ No
	the M	Director	MD Prince (Georges	Su	itland			10a. Cit	tizen of What	
	h with		6229 Auth Road				20746			USA	
	ems sermi	Funeral		Was Decedent Ever in U.S Armed Forces?	6. 13.			in? (Specify Yes or N Puerto Rican, etc.)	lo-		merican Indian,
30	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show soften Exemples must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		1∐Yes 2 ∏ 1		, , , , , , , , , , , , , , , , , , , ,		Specify:	Black
5-0036	2 hour		15. Decedent's Educ	ation	16a. Dece	dent's Usual Oc	cupation		16b. K	ind of Busine	
7		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	'life. I	DO NOT use re	/				
7	be filed withi ntal Hygiene. od other than event, Ire II		17. Father's Name (First, Middle, Last)	2	Prin	nting a	Superv	LSOY s Name (First, Middl			Gov't
and	buld be f Mental I larked ol	To Be	Alexander WII	lie					ning		
ary	ds and shared	H	19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailir	ng Address (Str	eet and Number	or Rural Route Num	ber, City	or Town, State	e, Zip Code)
χ, Σ	and 2 lealth a m 27 lt her tra		Diane C. Austin					or Ryral Route Num Street 20020			
HOLE	Pages 1 nent of H ant: If Ite ary or otl		20a. Method of Disposition 1 X Buriat 2 ☐ Cremation 3 ☐ Re	emoval from State		sition (Name of natory or other		Date		•	or Town, State
	nit. Pagartment ortant: I injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			on Nat		5/19/09			on, VA uneral Home
n	Dep.		10260	r Terry A. Au							
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	pations that caused the death							Approximate Interval Between
4	hysician	8 11	Immediate Cause (Final disease or condition								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	and	-fa. 0	111.0			< hugan
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XOD	eath certifica attending ph	M/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnal		7 Fatonia avanu			V.	23d. Date of	delivery
	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as	hysician/Me	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown		☐ Ectopic pregn ☐ Other (specify				Month	Day Year
7.	that the	Δ.	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not resu	ltina in the u	nderivina cause	given in Part I.	23e. Dio	l tobacco	use contribute	e to the cause of death?
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N Ea	clan: ertifica	Bec	25. Was case referred to medical examiner?					of Death (Check only			
	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		1 Yes 2 No H	ospital: 1 Inpatient 2 I	ER/Outpatier	IL 3 LI DOM		sing Home 5 Re			Specify)
	ding th: : After : funer	Certification: To	1 X Natural 5 Pending 2 □ Accident investigation	(Month, Day, Year)	Injury		Work?			how injury occurred	
<u> </u>	r Atter er dea rector by the	tifica	2 ☐ Accident Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)					28f. Location	(Street and Number or Rural Route Number, wn, State)		
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	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	Ician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, deat ion and/or in	h occurred at th vestigation, in r	e time, date and ny opinion, death	I place, and due to the h occurred at the tim	ne cause(: e, date an	s) and manne id place, and	r as stated. due to the cause(s)
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9			30. Name and address of person who con						1		20722
) V		Darlene Lawrenc 31. Date filed (Month, Day, Year)	e, MD 4151		ensbur	g Road	, Colmar	Maı	nor,MI	20722
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Registrar

MAY 1 1 2009 Cerus B. par

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5^{Day} 2009 6:40 AM May R. Schiappacasse Lorenzo 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Essex 8815 Golden Tree Lane 9. Birthplace (State or Foreign 8. Date of Birth (Month Day, Year) 05-25-1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 □ F Argentina 212-46-9508 84 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Baltimore Essex Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21221 8815 Golden Tree Lane 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify. White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Clothing Manufacturer College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gazpio Romulo L. Schiappacasse Maria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Mrs. Josefina Schiappacasse 8815 Golden Tree Lane Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 05-08-2009 Baltimore, Maryland 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair e. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 2001 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe

Physician /Medical **Examiner**

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Medical

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Physician: The certificate

Hospital or Attending

Box 68760.

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Physician

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should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

3altimore,

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner is ast two notified at

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant þ Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No

1 ☐Yes 2 ☐ No

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25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Manner of Death 1 Natural

29b. Signature and title of certifier

2 Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARLOS

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** LEVY SILVERSTEIN 7:30 ANNETTE 2009 Α 6, May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center 8. Date of Birth (Month, Day, Year) 07/29/1923 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Funeral 1 □ M 2 💢 F Days Hours Min. MD 216-14-4105 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important in the motified at any injury or other traumatic event, the Medical Experiment to motified at another. 1 X Yes 2 ☐ No BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21209 6811 GREENSPRING AVENUE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married WHITE 1 □Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCHLIEFFER **JOSEPH PICKENS** SHIRLEY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 6811 GREENSPRING AVENUE, BALTIMORE, MD 21209 ARNOLD SILVERSTEIN / HUSBAND 20b. Place of Disposition (Name of CHIZE) K AMUNO (CONGREGATION) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of ⊦ 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 05/08/2009 4☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. Signature of Funeral Service Lie 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neft hemispheric acute stroke **Physician** ~ Iday Large disease or condition resulting in death) /Medical Due to (or as a consequence of): Coronary artery disease
Due to (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last schemic Cardionyopathu uears and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria atrial fibrillation uear Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 pulmonary hypertension, hypertension 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No cate has been signal page 2 should b Completed chronic kidney disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation after death.

Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dex

To the Funeral Directo

completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065809 > Yeart 4. Dimaaro M.D. may 6, 2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rhett Gerard P. Dimaano, 670

6701 N. Charles St. Towson MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Voar 09254 **Physician** 2009 1 homas 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor lorthiclest Hospital MI andel 1st aulal 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 ☐ M 2 🕱 F 0-96-9934 Director Usual Residence of Decedent 10d. Inside City Limits the State 10h County 10c City Town or Location 28a-f show traumatic event, the Medical Examiner nast be notified at 1 XYes 2 ☐ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with to and Mental Hygiene.
Is marked other than "natural", or items 23a or? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 3 ₩ Widowed 4 Divorced ack Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) (9 Tunddaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traumonce. 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date rematory Mount 21. Signature of Funeral Service Licensee 22. Name and Address of Family JOSEPH L. RUS 2222 W. NOTTH hass Fi Balto. Md. 21216 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 36 hours **Physician** Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Urth Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐Yes 2 ☐ No Walnutrition 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 W No 1∐ Yes 2 ER/Outpatient 3 DOA 1 4mpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

e Funeral I

within 2

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of perso

(Month, Day,

and manner stated.

who completed cause of death (Item 23a) (Type, Print) d

Registrar's Signat

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0068505

29d. Date signed (Month, Day, Year)

000

09-03474	
Brad Trexler	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brad Trexler		St	ate of	Marylar	nd / De	epartme	ent of	Healt	h and	Menta	al Hyg	iene		0.0	0.0	. 1	E 0 2
	R	- For State egistrar				Certifica	ate of	Death	7		12	Date of De	Reg. No	. 70	3.	Time of De	ath O
Physician Medical Examine		. Decedent's Name (First, Middl			Tros	z1ar						Month April 30,		Year		0910 hr	1
Wedical Examine		la. Facility Name (if not institution	Brad n, give str	reet and num	Trex1er ber) 4b. City, Town, or Location of Death								c. County of De	ath			
,	H	Union Memorial Hosp	ital									N/A		(5)			
Funeral	7	5. Social Security Number	6. Sex	7	. Age (In y	rs. last birt	hday)	If Unde	r 1 Year Days	If Under Hours	Min.				Birthpla	.ce (State /)	or Foreign
Director		Unknown	1 X M	2F		51	Yrs.	I I I I I I I I I I I I I I I I I I I	Julyo			Feb.	7,	1958 P	<u>enn</u>	<u>sylva</u>	ania
any	-	Usual Residence of Decedent 10a. State 10b. County			10c.	City, Town	or Location	on							10	d. Inside (City Limits
<u> </u>			timo	ra		Cocke	evsvi	11e							1	Yes	2 X No
the Maryland a or 28a-f sh		Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What								itizen of What C	ountry	>					
with the Maryland as 33a or 28a-f show be notified at once.		10308 Sunny1	ake :	Place,	Apt	. F			21030					U.S.			
r death with or items 23 must be no	5	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rac Wh							14. Race - An White, etc		Indian, B	аск,					
r deat		1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify: Specify Yes, specify Cuban, Mexican, Fuerto Rican, etc.)							Specify:	Whi	te						
hours after death "natural", or ite Examiner must	핡	Widowed 4 Divided 15. Decedent's Education (Spe	or	Dates:	e complete	ed) 16a.	Decedent	's Usual	Occupation	on (Give ki	ind of wor	rk done	16b	. Kind of Busine			
72 hou "nai	Completed	Elementary/Secondary (0-12)		College (1-	4 or 5+)		during mo	ost of wor	king life. I	DO NOT u	ise retiret	a)					
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		17. Father's Name (First, Middle		0	т	1			- 1'			phine		Carli	ກລ		ŀ
212 ald be Menta marke	0 Re	Francis 19a. Informant's Name/Relation	ship (Type	C. e, Print)	Ir	exler	b. Mailing	Address	(Street	and Numi	ber or Ru	ral Route N	lumber,	City or Town, S	tate, Zi	p Code)	== 7,1
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Pages Pages nent of ant: I		4 Donation 5 Other S	pecify:			Hillt	op Se	ervi	ce Co	rp.	5 - 8-	2009		Towson		lary1	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		Stocatura Filteral Service	License	e						of Facility Roa	15 1 10	ck To	WSOI	n Funera Maryland	$\frac{1}{1} \frac{1}{2}$	iome,	Inc.
	\dashv	23a. Part I. Enter the disease, of	r complica	ations that ca	used the	death. Do r										Approxim	ate Interval Onset and
Physician Medical		failure. List only one caus	e on each	line. Narcot													eath
xaminer		Immediate Cause (Final diseas or condition resulting in death)		e to (or as a											\neg		
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50, tte be contraction hysicial entries	Medi	IF FEMALE:		23c. If yes, o	outcome o	f pregnanc	у							23d. Date of de	livery		
Box 68760, edeath certificate be the attending physici ed for use as the burn	ਗ	23b. Was decedent pregnant in past 12 months?	the	1 Live b		of death	-	etal death		Ectopio	pregnan	псу		Month	Day	1	Year
OX (eath or attence for use	<u>ي</u> .	1 Yes 2 No 9 U	nknown	g Unkno	ant at time own	o deali	5 0	ther (Spe	ecify)								
	Phys	Part II. Other significant cond	itions c		death bu	t not resulti	ing in the	underlyin	g cause g	jiven in Pa	art I.			cco use contribu			_
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eco he law ate has	Completed												erforme es 2		ith? ✓ Yes	2	No
of Vital Rec Jing Physician: The L. After this certificate funeral director, page	ø	25. Was case referred to media examiner?								of Death					-		
Vit	To B	1 ✓ Yes 2 No	Ho		Inpatient	2 ✔ ER/	Outpatien		DOM	Other ₄	`	g Home 5		sidence 6	Other:		
n of ding P 1. After funer:		27. Manner of Death 1 Natural 5 Pe	nding		ı, Day,Year)	·		litjury		Yes 2		unk					
24a. Was an autopsy performed? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Ves 2 No 1 Ves 2 No									eet and Number	or Rura	Route N	lumber, City					
hou hou	calC	29a. Certifier 1 Certifying	Physicia:	n: To the bes	st of my kr	nowledge, o	death occu	urred at the	ne time, d	ate and plant	ace, and	due to the	cause(s	s) and manner a d place, and due	s stated to the	i. cause(s)	
To the To the complet	Medical	29b. Signature and title of cert		and manner s	stated.					se number				29d. Date signed			
7.3	-	A Char	los	()					O.C.	M.E.				May 1, 2009			
06		30. Name and address of pers Laron Locke MD.		mpleted cau			a) 11 Pen	n Stree	et, Balti	more, M	1D 212	01					
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day, Month Mav 2009 1:52 a M Ward Robert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center Baltimore

9. Birthplace (State or Foreign Country)

Manyland Towson 8. Date of Birth
(Month, Day, Year)
July 26, 1939 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Min. 1 2 M 2 □ F 216-36-3040 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Sparrows Point 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21219 USA 8916 Chesapeake Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛣 No Specify White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legislative Aide 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Anna Gold James Joseph Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia J. Ward wife 8916 Chesapeake Avenue, Sparrows Point, MD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory May 14 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Md. 21222 Sign pre of 5un€al Service Licensee 23a. Part 1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SQUAMOUS CELL CANCER METASTARC Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 D No 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? RENTL FAILURG 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown RESPIRATIONY FATLURE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

burial-transi

aftending physician for use as the buria

certificate has been signed by the rector, page 2 should be detached

director,

After

124 hours after death.

Be Funeral Director: A pletely filled in by the funeral pub.

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and

Hospital or Attending Physician: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expanding to a notified at

Health and Mental em 27 is marked o

Department of Health Important: If Item 27 any injury or other tra

Pages 1 and 2

/Medical

Examine Physician/Medical

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Be Completed by Medical Certification: To

5 Pending investigation

6 ☐ Could not be

Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

fcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print) N Charlest SIZESSD POLUSOM,

State Registrar

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death villiamso Year **Physician** 1a 2009 /Medical 4c. County of Death Name (If not institution, give street and number) Town, or Location of Death Examiner arro If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Sept 3 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗹 F 007-44-7352 84 **Director** 1924 MA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event; the Me-Iteal Ex-miner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits CA Santa Clara Los Altos 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 757 Rose Lane 94024 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes &No Specify: white Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) medicine medical doctor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augustus Hemenway Eustis Elizabeth S. Bowditch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Augustus E. Williamson (son) 6 Upland Rd. S-2, Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 5-10-09 4 □ Donation 5 □ Other (Specify) Sykesville, MD **Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the hurtial-transit Medical Certification: To Be Completed by Physician/Medical

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	The state of the s			
21. Signature of Funeral Service Lice	•	22. Name and Address of Facility	Haight Funera	1 Home & Chapel
> Jaige Haigh	t Sterbert	P.O. Box 195 Syk	esville, MD 2	1784
shock, or heart failure. List only	nplications that caused the death. Do no one cause on each line.	197	diac or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Due to (or as a consequed e of	dementia		years
	Due to (or as a consequence of).		/
Sequentially list conditions, if any locating to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a consquence of	¥:		
that initiated events resulting in death) Last	cDue to (or as a consequence of	·):		
	_d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2 Î	ise contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of I	Death (Check only one)	
1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 DOA Other: 4 Nursin	g Home 5 ☐ Residence 6	3 □Other (Specify)
27. Manner of Death All Natural 5 Pending Colored Investigation	n	me of ury 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injur	y occurred
3 Suicide 6 Could not be determined		n, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
29a. Certifier 1	hysician: To the best of my knowledge, miner: On the basis of examination and/ and manner stated.	death occurred at the time, date and pl or investigation, in my opinion, death of	ace, and due to the cause(s) ccurred at the time, date and	and manner as stated. I place, and due to the cause(s)
29b. Signature and title of confifer	-	29c. License number		e signed (Month, Day, Year)
171./		D0062791		5/8/09
Nicholas	completed cause of death (Item 23a) (T	ype, Print) 110 Obrecht Ra	1. Sykosi	Ile 21074
31. Date filed (Month, Day, Year)	32 Registrar's Signature			

State

Registrar

MAY 1 1 2009

parke

12. Was Decedent Ever in U.S. Armed Forces? 1 ▼1 Yes 2 □ No If Yes, Give Year or Dates:

College (1-4or 5+)

10d. Inside City Limits 1 ☐ Yes 2 😿 No

Birthplace (State or Foreign
Country)

Maryland

6:00 A M

USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,

2009

4c. County of Death

Anne Arundel

Specify: White 16b. Kind of Business/Industry

Black. White, etc.

10g. Citizen of What Country?

(Give kind of work done during most of working life. DO NOT use retired) Sporting Goods 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last) John B. Wyatt, Sr.

1 ☐ Never Married 2 € Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

10h County

Anne Arundel

15. Decedent's Education (Specify only highest grade completed)

3645 Solomons Island Road

10a. State

Director

Funeral

þ

Completed

Be

MD

11. Marital Status

10e. Street and Number

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be fill ment of Health and Mental Health ant: If item 27 is marked oft

permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.

Physician

/Medical

Examiner

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attending pl

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page

neral Director; , filled in by the fu

The law requires that the death certificate be executed

or Attending Physician:

the Hospital within 24 hours a

To the Funeral I

completely filled

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

ş

Completed

Be

Certification: To

Medical

Dolly Ann Haskett

Specify:

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3645 Solomons Island Road Harwood, MD 20776

20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem.

Sales

10f. Zip Code

1 ∐Yes 2**X** No

16a. Decedent's Usual Occupation

20776

10c. City. Town or Location

Harwood

5/11/2009 22. Name and Address of Facility

20c. Location - City or Town, State Timonium, Maryland

19a. Informant's Name/Relationship (Type. Print)

Doris Ann Wyatt / Wife

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Towson, Maryland 21204 Inc. 1050 York Road Ruck Towson Funeral Home, Approximate Interval Between Onset and Death

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Ischemie

Due to (or as a consequence of):

1000

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23d. Date of delivery Day

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

30. Name and addres

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

death but not resulting in the underlying cause give

. Date of Injury (Month, Day, Year)

9 Unknown

Hospital:

0 25. Was ca e referred typedical examiner?

24a. Was an autopsy perform 1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To, he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 redical Examiner: On Lee basis of examination and/or investigation in the control of the cause (s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and lianner stated.

29b. Signature and title of

(Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

5 Pending

investigation 6 Could not be determined

Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State				artment of F		nd Mental Hy	0	000	1501	0
			= State RegistrayEND#19a, perf		,MOLO	Cer	tilicate of	Deam	2. Date of D	Reg. No.	009	3. Time of Deat	1 J
	Physicia /Medic		Abdul Rah:	· ·	keefe				Month	Day 200	9 Year	5:53 A.	M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of			nty of Death		
and the			Holy Cross Hospi				Silver S				gomery		
	Funeral Director		5. Social Security Number 6 246-47-2711	. Sex 7. Ag 1X M 2 □ F	je (In yrs. l 74	ast birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of Bi Min. 0CT •]	Pay, Year) 193	. Cou	place <i>(State or For</i> ntry) 1anistan	eign
	D		Usual Residence of Decedent							,			
	arylar show	2	10a. State 10b. County			y, Town or Lo						10d. Inside City Lin 1 □Yes 2	
	the M	Director	Maryland Montgom	ery	Sil	ver Sp	ring 10f. Zip Code			10g. Citizen	of What Cou		
	3a or	io le	3401 Kayson Stre	et			20906			United		•	
	death	Funeral I	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13. V	Was Decedent of H	lispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)	0- 14. !	Race - Ameri Black, White,		
220	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaninal mast be a cliffed at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ⊟Yes 2 📉 I If Yes. Give			I □Yes 2 No	Specify:			ecify: Whi		
3	tural	ed b	15. Decedent's	Year or Dates:		16a. Deced	dent's Usual Occup	ation		16b. Kind o	WILJ f Business/Ir		
2	hin 72 e. an "na	Completed	(Specify only highest Elementary/Secondary (0-12)		5+)		kind of work done OO NOT use retired	during most o d)	of working				
7	ed wit ygien yer tha	Con		5+	,	Profe	ssor			Educa			
2	2 should be filed withi and Mental Hygiene. is marked other thar aumatic event, Inc.	Be	17. Father's Name (First, Middle, La	st)					s Name (First, Middle		name)		
Ě	thould nd Me mark matic	ဥ	Haidar Ali	(Type Print)		19h Mailin	ia Address (Street		ry (Unava:		wn. State. Zi	n Code)	
2	1 and 2 s Health ar tem 27 is		19a Informant's Name/Relationshir Yama, Akeele, S Yana Akeele, Son	on serving		1			e, Rockvil				
ָר ב	es 1 a of Hea ritem		20a. Method of Disposition		20b. P	lace of Dieno	cition (Name of		pril 26,		on - City or T		
	Page ment ant: It		1 ABurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Geo	rge Wa etery	shington shington	2	009	Adelp	hi, Ma	ryland	
	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Lie	ensee	1601	7 Z2	Name and Addre hibadeau	ss of Facility Mortu	ary Servic	e, P.A			
			23a. Part 1. Enter the disease, or co	omplications that caused	MO1				LL, Silver		g, MD	20910 Approximate Interval Between	
	Physician [®]	0 1	shock, or heart failure. List or Immediate Cause (Final	ly one cause on each li	ne.						1	Interval Between Onset and Death	ì
	/Medical		disease or condition resulting in death)	a. ARTERIUS Due to (or as			ARDIOVASO	JULAK .	DISEASE				
	Examiner		Sequentially list conditions	b									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is it leads to the cause)	Due to (or us	a consequ	rence of):							
	execut and al-tran	хап	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):			1				
3	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E		d.									
3	ng phy as th	Medi	IE EEMALE.						fortifier.				
Š	eath certific attending p for use as	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 \subseteq Live birth	2 🗆 Fetal	death 3	Ectopic pregnanc	y		23d.	Date of delive	very Day Year	
S	the de	Physician/Me	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5∟	Other (specify) _					,	
	that the de ned by the detached		Part II. Other significant condition	s contributing to death b	ut not resu	ılting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use o	ontribute to	the cause of death	?
2	quires en sign uld be	ed by							1□	Yes 2□N	o 3□ Pro	bably 4∭ Unkno	own
ב ט	law requir as been s 2 should	plet							24a. Wa	s an 24	b. Were aut	opsy findings availa ompletion of cause	able
	sician: The certificate h rector, page	Completed							per 1 □ Yes	rormed?	death?		01
2	Attending Physician: The redeath. ector: After this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?	Hospital:			Oth		of Death (Check only	one)			
5	Phys r this ral dir	<u>ا:</u>	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatien 28b. Time of		4 LI Nuis	sing Home 5 Res	how injury oc		ify)	
5	rding Ph th. : After th e funeral	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Da	y, Year)	Injury	Worl	k? Yes 2.∐No		- 11011 1111011111111111111111111111111	-		
2	er dea	Certification:	3 ☐ Suicide 6 ☐ Could no determine		ury - At ho	me, farm, stre	eet, factory, office			(Street and No	ımber or Ru	ral Route Number,	
5	ital or irs afte ral Dii lled in	Cer											
	To the Hospital or Attend within 24 hours after death to the Funeral Director: / completely filled in by the formulation of the	edical		Physician: To the best aminer: On the basis o and manner sta	of examinat								
	ro the vithin	Med	29b. Signature and fill of confifier	7	atou.		29c. Licens	e number		29d. Date si	gned (Month	, Day, Year)	
b	5		1//100	= MO			D6429	96		APRIL	24, 20	009	
7			30. Name and address of person wh	·	,		Print)						
	-01		RICHARD NGUYEN, 31. Date filed (Month, Day, Year)		FORE:		NN ROAD,	SILVE	R SPRING,	MD 209	10		
	Star Registra		APR 27 20		1.	par	20						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 19:10P James Andrew Atwell, Sr. April 23. 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Clinton Prince Georges Maryland Hospital Southern Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 6. Sex Months Days Hours 1 🕅 M 2 🗆 F 55 212-62-1263 January 9,1954 Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 X No Charles Waldorf MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20601 Pinefield Way 2225 12, Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐Yes 2 No Specify White Specify. 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Seepndary (0-12) College (1-4or 5+) Federal Govt. Roofer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Douglas Stewart Atwell Greta Ann Petersen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6705 Amherst Rd. Bryans Road, MD Rosemary Hodgson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. 4/27/09 Charlotte Hall,MD 21. Signature of Funeral Service Licensee M00945 Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cchas Approximate Interval Between Onset and Death Immediate Cause (Final a ACUTE ATHEROSCLEROTIC CARDIOVASCULAR DISENSE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 MR/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a After this certificate has been s funeral director, page 2 should

Physician

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be rediffied at once.

altimore, Maryland 21215-0036

Physician/Medical <u>≨</u> Completed Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 🗖 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

K. Mahugen MD

D50689.

0412412009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHILE MAHA 7 200. M D

7503 SURRATTS RA CLINTUM MD 20739 CENTER

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 27 2009

SOUTHERN MARYLAND

HURPITAL 32. Registrar's Signature ener

n 24 hours a er death. e Funeral Director. Aff eletely filled in by the fun

within 24 hor To the Fune completely fi

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at agree.

Physician

Baltimore, Maryland 21215-0036

/Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	For State Grant Registrar	Cer	tificate of Dea		Reg.	No. 2009	15	045		
	1. Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of	Death		
an cal	Michael William	And	derson	A		26 2009	2:30	РМ		
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County of Death				
	307 Radcliff Ave.		Hagerstown			Washingto				
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)		ours Min.	Date of Birth (Month, Day, Ye	a <i>r) Cou</i> i		r Foreign		
	220-17-1374	26 Yrs.		M	arch 3,	1983 Mary	Land			
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			1	0d. Inside Cit	y Limits		
ò	Manual and Stanford	TT +					1 Yes	2 🗌 No		
rec	Maryland Washington	Hagerstow	10f. Zip Code		10g.	Citizen of What Cour	ntry?			
ä	307 Radcliff Ave.		21740			U.S.A.				
Jera	11 Marital Status 12. Was Decedent	Ever in U.S. 13. V	Vas Decedent of Hispan Yes, specify Cuban, Me	ic Origin? (Speci		14. Race - Americ				
Ξ	1 Never Married 2 Married 1 Yes 2 Kil	No I			can, etc.)	Black, White,	etc.			
by	3 ☐ Widowed 4 ☐ Divorced Specify: Specify: Specify: Whi									
Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?										
du	Elementary/Secondary (0-12) College (1-4or 5	5+)	OO NOT use retired)	_						
ပိ	12 17. Father's Name (First, Middle, Last)	Dry W	all Stocker		First, Middle, Maid	Building S	Supply			
Be										
ဥ	Michael E. Anderson	40h Mailin	g Address (Street and N	eanie E			n Cadal			
	19a. Informant's Name/Relationship (Type. Print)									
	Jeanie E. Anderson / Mothe:	20b. Place of Dispos	Radcliff av	re. Hage		Maryland 2 Location - City or To				
	1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem Chur	<i>atory or other place)</i> ch Cemeter y	7						
	21. Signature of Funeral Service Ligensee	\$t. Pauls	Lutheran	4/30/2	2009 Le	itersburg.	Maryl	and		
	18-615-		601 Pennsvl				_	21742		
	23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente	***				Approximate Interval Bet	3		
	shock, or heart failure. List only one cause on each li Immediate Cause (Final	ne.	. A				Onset and D	Death		
	disease or condition resulting in death) Due to (or as	a consequence of):	, Lymph	DING) /2 9	1/1		
	Sequentially list conditions b.									
ner		a consequence of):					_			
am	Cause (Disease or injury that initiated events resulting in death) Last	_								
<u>=</u>	Due to (or as	a consequence of):								
Medical Examiner	d			-						
₩e	IF FEMALE: 23c. If yes, outcome	of pregnancy				22d Date of delic	·on.			
Sian	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month		/ear		
Physician/N	1 Yes 2 No 9 Unknown	a anno or dodan	Cirio (apoony)							
V Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the un	nderlying cause given in	Part I.	23e. Did tobac	co use contribute to	the cause of d	eath?		
Completed by				~~~	1 ☐ Yes	2 No 3 Pro	bably 4 🗖 l	Jnknown		
Set					24a. Was an	24b. Were autoprior to co	opsy findings	available		
Ĕ					autopsy	death?		ause of		
BeC	25. Was case referred to medical		26.	Place of Death (1 □Yes 2 ☑ (Check only one)	ino i la fes	2 🗆 140			
	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	Other			e 6 ☐Other (Spec	ify)			
Ë	27. Manner of Death 28a. Date of Inju	ury 28b. Time of Injury	28c. Injury at Work?	28	d. Describe how	njury occurred				
aţi	2 Accident investigation	ly, rear)	M 1 ☐ Yes	2 🗆 No						
tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury	ury - At home, farm, stre	eet, factory, office	28	If. Location (Stree City or Town, S	t and Number or Rui	al Route Num	ber,		
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Medical Certification: To	29a. Certifier 1 Certifying Physician: To the best (Check only 2 Medical Examiner: On the basis of	of examination and/or inv						;)		
Med	one) and manner st 29b. Signature and title of certifier	ated.	29c. License nur	mber	29d.	Date signed (Month	. Dav. Year)			
	Michael Michael	MO					-			
	30. Name and address of person who completed cause of	teath (Item 23a) (Type I	Print)	40/		(0 47			
	Michael McCorno	il	04 Print) 10 Med	ical lo	mus I	Haronho	va m	0.		
ate	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature		,	-, -, -,	V . ()				
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2001										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? () 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Year APRIL **Physician** 11:02 P M ANDING ALICIA Υ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 9 1971 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 ⋤ F WASHINGTON, DC 217-11-4309 37 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinat houst be netited at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 ☐ No Director CHARLES LAPLATA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5720 DURHAM COURT 20646 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RENEE BERNARD EDWARD LONG ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5720 DURHAM COURT LAPLATA, MARYLAND ADRIAN D. MATTHEWS/AUNT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND RIVERDALE CREMATORY 4/28/2009 4 ☐ Donation 5 ☐ Other (Specify) J. B. JERKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bilateral Preumo in a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician the attending philographics at the ase : IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ mouno det ciena 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Kena certificate has page 2 autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 **□**√No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Ana/ 24 D0055120 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHM11 17 Flev 1/2001

Date filed (Month, Day, Year)

APR 2 8 2009

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1328 Jontham avenue

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:05 p ^M April 22 2009 Charles Adegbesan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Takoma Park Washington Adventist Hospital <u>Montgomery</u> Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Yrs 220-94-6628 51 16 1958 Nigeria April Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exyr inter must be rediffed at once. 1y Yes 2 □ No Director MD Prince George's Springdale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9208 Hobart Street 20774 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5 t Elementary/Secondary (0-12) Private Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augustine Adegbesan Antonia Onatolu ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christina Adegbesan/wife 9208 Hobart Street, Springdale, MD 20774 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery May 2 2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. | cate has been signed by the page 2 should be detached 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BA State

Medical

Registrar

29a. Certifier

(Check only one)

29b. Signature and title

certifie

32. Registrar's Sign

cause of death

and manner stated.

5

(Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** Armstrong Mae Madeline /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** Hagerstown Washington Washington County Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 21,1926 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours Min. 1 □ M 2 🛛 F Sept. Ohio 215-20-8238 Director 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evander must be redthed at once. 1 ☐Yes 2 No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10911 Decker Ave. 21740 U.S.A. Funeral Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1□Yes 2XNo 3altimore, Maryland 21215-0036 Specify: Specify: ≥ White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David W. Ausherman Ida Carter ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Pompell/Daughter 21740 12313 Learning Lane, Hagerstown, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 5/5/2009 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluster heart line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 HNO certificate 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Pes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred Date of Injury (Mont), Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? IZODM 1 Natural 5 Pending investigation 10/09 1 ☐ Yes 2 ☑ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 10911 Decker Ave Hügerstown, MD 21740 6 ☐ Could not be Pla of In ary - At home, farm, street, factory, office building, e.c. (Specify) 3 Suicide

Division of Vital Records, P.O. Box 68760, ours after death. neral Director: Af filled in by the fur e Funeral I completely within 2.

> State Registrar

Medical

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Name and

Inomas 31. Date filed (Month, Day, Year) DO, FACET

who completed cause of death (Item 23a) (Type, Print)

rt Ⅲ, ∭ 32. Registrar's Signature

intert

1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number #40884

251 E. Antietam St. Hagerstown, MD 21740

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

		Atkinson State of Marylar 1- For State Redistrar	Certificate	of Death	Reg. No.	2009 150						
Physicia cal Exami	an/	1. Dècedent's Name (First, Middle, Last) Christopher J.	Atkinson		2. Date of Death Month Day Yea May 2, 2009	3. Time of Death 0319 hrs						
		4a. Facility Name (if not institution, give street and num Hurleys Neck Road	ber)	4b. City, Town, or Location of Deat Mandela SpringMarde	h 4c. County of							
Funeral Director		5. Social Security Number 6. Sex 7 94–58–6320 1X M 2 F	7. Age (In yrs. last birthday 39	y) If Under 1 Year If Under 24Hr Months Days Hours Mi	_	9. Birthplace (State or Foreign C 小をw York						
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits						
Maryland 28a-f show d at once.	tor	Maryland Wicomico 10e. Street and Number	Mardela	a Springs	10g. Citizen of W	1 Yes 2 No						
th the Maryland 23a or 28a-f sho	Director	8604 Hurleys Neck Road		21837	USA							
2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed For		. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puerl		e - American Indian, Black, e, etc.						
s after de ral", or niner m	by Fu	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1	Yes 2 X No specify: edent's Usual Occupation (Give kind o	Specify:	white usiness/Industry						
72 hours af in "natural :al Examin	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4)	4 or 5+) durin	ng most of working life. DO NOT use re	etired)							
led within 72 Hygiene. other than " the Medical	omb	11 – 17. Father's Name (First, Middle, Last)	scr	reen operator 18. Mother's Name	paving ne (First, Middle, Maiden Surname	company						
uld be filed with Mental Hygiene marked other th	Be	John J. Atkinson	40h M	Geral lailing Address (Street and Number o	dine L. Weidtma							
and 2 shoule lealth and M tem 27 is m traumatic e	ို	19a. Informant's Name/Relationship (Type, Print) John Atkinson/father	9	543 Athol Rd., Ma	rdela Springs,	MD 21837						
permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	m State 20b. Place of Di crematory of Wicomic	sposition (Name of cemetery, or other place) co Memorial 5		- City or Town, State						
permit. I Departme Importai		21. Signature of Funeral Service Liberton	1	² 416116WayesFtheral 501 Snow Hill Rd	Home Profession	nal Association 21804						
nysician Medical		23a. Part I. Enter the disease, or complications that car failure. List only one cause on each line.	used the death. Do not en									
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ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital:		26.Place of Death (Che		Other Spane						
hysic this	⊢	1 ✓ Yes 2 No		atient 3 DOA Offe 4 Nur ne of Injury 28c. Injury at Work?	28d. Describe how injury occu	✔ Other: Scene						
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the Hospital or Attending Pi hin 24 hours after death. the Funeral Director: After upletely filled in by the funeral	lical Certification:	3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of the ba	Local Street t of my knowledge, death f examination and/or inve	occurred at the time, date and place, a	Hurleys Neck Road, Mand	ner as stated.						
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical Certification	3 Suicide 6 Could not be 4 Homicide 28e. Place (Specify) 29a. Certifier 1 Certifying Physician: To the hest	Local Street t of my knowledge, death f examination and/or inve	occurred at the time, date and place, a estigation, in my opinion, death occurre 29c. License number	Hurleys Neck Road, Mand and due to the cause(s) and mann d at the time, date and place, and 29d. Date significant in the signif	ner as stated. d due to the cause(s) gned (Month, Day, Year)						
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		1 - State of Maryland Registrar	•	tificate of L			leg. No.			
Dhusi		1. Decedent's Name (First, Middle, Last)				Date of Dea Month	Day	Year	3. Time of Death	
Physic Mec/		Lena A. Bogden			/ D W	April 1		009 ounty of Death	10:05 A M	
Exam	iner	4a. Facility Name (If not institution, give street and number)			Location of Death	,				
./ 		Alfred House Eldercare 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	Silver If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Day	MO1	ntgomer 9. Birth Cou	place (State or Foreign	
Funera Directo			3 Yrs.	Months Days	Hours Min.	06/19/1		Ohi		
pt ,		Usual Residence of Decedent	Town or Lo	nation				1	10d. Inside City Limits	
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the M 28a-f	Director	MD Montgomery Gait	hersb	erg 10f. Zip Code			10g. Citize	n of What Cou	ntry?	
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death ms 2:	Finara	2005 Doolittle Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-		. Race - Ameri Black, White,		
VIZ.15-UU30 within 72 hours after death with the Maryland glene. Trans "naturals", or items 23a or 28a-f show the Madical Examitres must be notified at	i i			1 □Yes 2 X No	Specify:	, , , , , , , , , , , , , , , , , , , ,	i	pecify:		
72 hours aff	2	3 ☑ Widowed 4 □ Divorced Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind	White of Business/Ir	ndustry	
in 72	Completed	(Specify only highest grade completed)	(Give life. I	kind of work done on NOT use retired	during most of work d)	ring				
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Alar 2 sho 1 and 1 s m		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street						
e, land 1 and Healt em 27		Donna Lee Galbo / Daughter 20a. Method of Disposition 20b. Pla	2005_] ace of Dispo	Doolittle sition (Name of matory or other place	St. Gai	thersber Date	20c. Loca	20886 ation - City or T	own, State	
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Division of Vital Records, for Attending Physician: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be or a limby the funeral director, page 2 should be or a limby the funeral director, page 2 should be or an area.	6	25. Was case referred to medical examiner?		Ott	26. Place of Dea					
Of Physic rthis cral direction		1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ E 27. Manner of Death 28a. Date of Injury	ER/Outpatie 28b. Time o	III 3 LI DOA	44 <u>1</u> Nuising i	lome 5 ☐ Res			cify)	
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DIVISION Of VIta I or Attending Physician: after death. Director: After this certific din by the funeral director, I in by the funeral director, I	1	27. Manner of Death 1 X Natural 2 Accident investigation 3 Suicide 6 Could not be determined 1 Inpatient 2 E8a. Date of Injury (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Place of Injury - At hot building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location	(Street and wn, State)	Number or Ru	ural Route Number,	
pital or purs afte eral Dire		4 notificide building, etc. (Specify								
		29a. Certifier (Check only (Check only) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat	wledge, dea ion and/or i	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner a place, and due	s stated. to the cause(s)	
To the Hos within 24 h To the Fun completely		one) and manner stated. 29b. Signature and title of certifier			se number			e signed (Mont		
		> Potele Domes, MD		D006	2999		Apri	1 17,	2009	
8		30. Name and address of person who completed cause of death (Item	23a) (Type							
		Petek Donmez, M.D. 11119 Rock			01Rocky	ville, M	D 20	852		
	State	Of Date filed (Menth Day Year) 2 Registrar's Signat	ure -	120		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 00 Chester R. Brenneman, Jr. 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) GIEN BURNIE AMNE SAUTINUPE WAS HINGTON MEDICALC If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months **1**XX M 2□ F 90 March 12, 1919 577-09-9762 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location 1 ∐Yes 2√X No Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21108 8019 Horicon Point Drive 12. Was Decedent Ever in U.S. Armed Forces? 1♥□ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes XXNo Specify White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Central Office Repairman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isabel Garver Chester R. Brenneman 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8019 Horicon Point Drive, Millersville, MD 21108 Robert W. Brenneman /Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State April 29, 2009 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) arklawn Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 or, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final MUGESTIVE disease or condition resulting in death) Due to (or as a consequence of): 2515 Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 131211 Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the "heart and it with the next be netitived an once.

Baltimore, Maryland 21215-0036

PRINCE AL

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

Funeral

Director

attending physician and for use as the burial-tran the ģ signed I s certificate has the irector, page 2 st After t

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

To the I

Division of Vital Records, P.O. Box 68760,

								24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case refer	red to medical	/				26	Place of Deat	th (Check only one)	
examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 Inpa	itient 2 🗆	ER/Outpatient	me 5 Residence 6 Other (Specify)				
27. Manner of Deatl 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	1	njury Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes	2 □No	28d. Describe how injury	occurred
3 Suicide 4 Homicide 6 Could not be determined City or Town, State) 286. Could not be determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							l Number or Rural Route Number,		
29a. Certifier (Check only one)			of examinat					, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print) O

29d. Date signed (Month, Day, Year)

Year) 31. Date filed (Month, Day, 27

29b. Signature and ville of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:15 p M 2009 Harry Russell Bissett Sr. April 22. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 10600 Huntley Place Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**XX**M 2 □ F 82 578-22-2630 June 20, 1926 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must by notified at 1 ☐ Yes 200 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20902 10600 Huntley Place Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. filed within 72 hours after Hygiene. 1 Never Married XX Married Maryland 21215-0036 1 □Yes 2√X No Specify Specify White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Parts Manager Automobile Dealership permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Thomas Bissett Marion Lee Hamilton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frances Eileen Bissett 10600 Huntley Place, Silver Spring, MD 20902 altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State April 26, 2009 Alexandria, VA 5 ☐ Other (Specify) Metropolitan Crematory 4 ☐ Donation 21. Signature Funeral Service icense 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 months Myelodysplasia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 X No has 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**/CX**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation n 24 hours after death.

e Funeral Director: Af
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Fune

completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 April 26, 2009 D33224 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram Trehan, 1400 Forest Glen Rd, Suite 435, Silver Spring, MD 20910 31. Date filed (Morlth, Day, Year) Registrar's Signatu State 27 Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrar	tate of Maryland / De <i>C</i>	epartment of t Certificate of		, ,	iene _{eg. No.} 2005	3 15053
Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Deat Month	h Day Year	
/Medic	cal	Marguerite Marie Bechte		4h City Town	r Location of Death	April 18	4c. County of Dea	6:15p ^M
Examir	er	4a. Facility Name (If not institution, give stree Manor Care-Silver Sprin			r Spring		Montgome	
Funeral Director		5. Social Security Number 6. Sex 1 □ M	2X F 7. Age (In yrs. last birthe	Months Days	Hours Min.	8. Date of Birth (Month, Day, November	Yea <i>r)</i> 9. Bi	rthplace (State or Foreign Country) France
and ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
Maryl a-fsho ffed	tor	MD Montgomery	Silv	er Spring				1 X Yes 2 ☐ No
h with the 23a or 28a	Funeral Director	10e. Street and Number 2501 Musgrove Road, Roc	m 108-B	10f. Zip Code	20904	11	0g. Citizen of What C USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exprint at must be notified at once.	þ	1 Never Married 2 Married	Nas Decedent Ever in U.S. Armed Forces? □Yes 2 XX No 1Yes, Give rear or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes ※XX No		cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
thin 72 here.	Completed	15. Decedent's Educatio (Specify only highest grade col	n 16a. D mpleted) (0 College (1-4or 5+)	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	oation during most of workin d)	og	16b. Kind of Busines: Own Ho	-
led wi Hygier ther th		12 17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name	/First Middle A		
id be filental ked of	To Be	Yves Simier			Isabelle I			
INICALLY nd 2 shou alth and N 27 is mar		19a. Informant's Name/Relationship (Type. In Michelle Bechtoldt / Date	· ·	Mailing Address (Street 1717 Harborvie				Zip Code)
Pages 1 and not of Hermann: If item and: If item and or other or other and or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		isposition (Name of crematory or other pla leaven Cemete		1	20c. Location - City o	
Departit. Departr Imports any Inju		21. Signature of Funeral Service Licensee Aus M Areva	6	22. Name and Addre Francis J 500 Unive	ess of Facility • Collins Furnsity Blvd.	neral Hom West, Sil	e Inc. ver Spring,	MD 20901
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death. Do not	enter the mode of dyi	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Dementia					Onoot and Dodin
Examiner			Due to (or as a consequence of) Sacral Ulcer					
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)					
xecute and I-trans	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequence of)					
tificate be executed g physician and as the burial-transit	edical E	d						
± 00 €		IF FEMALE:						
The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy I □ Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Су		23d. Date of d Month	elivery Day Year
s that med by	by Ph	Part II. Other significant conditions contribu	uting to death but not resulting in the	ne underlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
w requires s been sign should be	ed b	Seizure Disorder				1 ☐ Ye	es 2 /∑ (No 3 □ I	Probably 4 Unknown
The law rate has be	Completed	Schizophrenia				24a. Was ai autops perform 1 □ Yes 2	y prior to ned? death?	autopsy findings available completion of cause of
ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	ital:	Ott	26. Place of Death	(Check only on		
Phys er this eral dir	۲: To	TO TES ZINO	8a. Date of Injury 28b. Tin	ne of 28c. Inju	4AAA Nursing Hon		ence 6 Other (Sp ow injury occurred	pecify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	Certification:	1XXNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	(Month, Day, Year) Inju 8e. Place of Injury - At home, farm building, etc. (Specify)	M 1 □	lYes 2□No	28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
Hospital 24 hours Funeral stely filled	Medical Co	(Check only 2 Medical Examiner:	n: To the best of my knowledge, on the basis of examination and/	death occurred at the tor investigation, in my	ime, date and place, a opinion, death occurre	and due to the c ed at the time, d	ause(s) and manner ate and place, and do	as stated. ue to the cause(s)
Fo the within Fo the comple	Mec	29b. Signature and title of certifier	, •	29c. Licens	se number	2:	9d. Date signed (Mor	nth, Day, Year)
B		Van H	eu		53235 		April 23,	, 2009
15		30. Name and address of puson who complete Darryl A. Hill M.D.	13635 Baltimo		outh Lakes Of	fice Park	, Laurel, M	20707
Sta Registr	AC 1	31. Date filed (Month, Day, Year) APR 27 2009	32 Registrar's Signature	acid.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2009 **Physician** 24, 12:05 PM April Robert Ellsworth Beatty /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/27/1926 Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1**⊠** M 2□ F 82 Director 579-26-4424 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Musical Examinar must be notified at Director Maryland Montgomery Rockville 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 5420 Wickford Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2x Married 2 😾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: White Ş Q 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AMCO Products Business Owner 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John J. Beatty Helen Simpson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Geddes Beatty / Wife 5420 Wickford Dr. Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery 04/27/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Strvice Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Finer the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immed e Cause (Final **Physician** neumone disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a Was an certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in more in the cause of examiners and the cause of examiners and the cause of examiners. 29a. Certifier Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier_ 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

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ROBER

BEATTY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03417 State of Maryland / Department of Health and Mental Hygiene Scott Baranowski 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 28, 2009 Year Medical Examiner BRIAN SCOTT BARANOWSKI c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Flinstone Green Ridge State Forrest 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday 6. Sex **Funeral** Social Security Number Hours Months Days Director 1970 Country) 39 MARCH 6 214-08-4698 1 X M 2 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10a. State 28a-f show BOONSBORO MARYLAND WASHINGTON must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21713 16 STOUFFER AVENUE 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11. Mantal Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Armed Forces? Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after c
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or
injury or other traumatic event the Marian. Divorced Yes, Give Yea Yes 2 X No specify: Widowed <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) SYSTEM SPECIALIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>JANIS LEA JEFFERIES</u> EDWARD RAYMOND BARANOWSKI JR. 19a. Informant's Name/Relationship (Type, Print) ဥ BOONSBORO. 16 STOUFFER AVENUE, KELLY M. BARANOWSKI/SPOUSE 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 4/30/2009 STAUFFER CREMATORY Other Specify: **\$**ignatu uneral Septice Licensee Paul M. Dear 7606 Old National Pike, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. 'Medical a. Contact Gunshot Wound of Head Immediate Cause (Final disease camine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical physician the burial -UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. The law requires that the o þ ۵ Completed Records, 24a. Was an autopsy has performed' Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical

WHITE 16b. Kind of Business/Industry TEMPERATURE CONTROL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLAND 20c. Location - City or Town, State FREDERICK, 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME Boonsboro, MD 21713 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes No To the Hospital or Attending Physician: of Vital Be Other₄ examiner? Hospital: 4 Residence 6 Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 DOA this 1 V Yes ို 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred 27. Manner of Death After Certification: Subject shot self FOUND: Division Natural Yes 2 V No Pending To the Funeral Director: the Apr 28, 2009 0810 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) Green Ridge State Forrest, Flintstone, MD determined (Specify) Park/Recreation Area Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) SH-15 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD trar's Signature State Market . Registrar OCME **ORIGINAL** DHMH 17 Rev 1/2001 OCME 2006

0934 hrs

MARYLANI

10d. Inside City Limits

1 X Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10.15 XM **Physician** 7000 Rita F. Berry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland AGNES Baltimore OSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days 1 □ M 2X F Hours 579-22-8053 86 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show other than "natural", or items 23a or 28a-f showent, the Medical Evaminer must be notified at 1 □ Yes 2X Wo Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 719 Maiden Choice In. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1943If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Medical Technologist Healthcare 4 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Tiemeyer Edward L. Frey ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7615 Bear Forest Rd., Hanover, MD 21076 Department of Health a Important: If item 27 is any injury or other tra Dr. Robert Z. Berry, Jr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/2/2009 Ardent Cremation Hanover, MD To □ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility larry H. Witzke's Family FH, Inc. M0141121. Signature of uneral 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE cate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐ Yes 26. Place of Death (Check only one) funeral director. 25. Was case referred to medica Hospital: 1☐Yes 2☐No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural ospitar c. .4 hours after dea. ∵al Director: Aftr 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Majden Choice Ln Codonsville MD

ie.	Registrar 1. Decedent's N	lame (First, Middi	e, Last)			rtificate of		2. Date of De Month	Day	Year	3. Time of Death
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iner		e (If not institution yrol Dri	n, give street and n	umber)		4b. City, Town, o		of Death		County of Death ince Ge	
	5. Social Securi		6. Sex	7. Age (In yr	s. last birthday)	Springda If Under 1 Year	If Unde	r 24 Hrs. 8. Date of Bi	irth	9. Birth	nplace (State or Foreign
l r	229-07		1 ☐ M 2 🛣 F	106	Yrs.	Months Days	Hours	Min. (Month, D			intry) \ i nia
	Usual Residence			100.0	ity, Town or Lo	ecation					10d. Inside City Limits
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ecto	MD 10e. Street and		e George'	s Sp	ringdal	10f. Zip Code			10g. Citiz	zen of What Cou	untry?
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by Funeral Director	11. Marital Stat		12. Was De Armed I	3 2 x No Give	1		Hispanic O an, Mexica	origin? (Specify Yes or N an, Puerto Rican, etc.)		14. Race - Amer Black, White Specify: B1	
Completed t	(3	15. Deceder Specify only highe	nt's Education est grade completed	d)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mo	ost of working	16b. Kir	nd of Business/I	ndustry
amo	Elementary/S 6th	Secondary (0-12)	College	(1-4or 5+)	_	stress	,		Pri	vate	
Be C	17. Father's Na	me (First, Middle	,	-			18. Moth	her's Name (First, Middle	e, Maiden	Surname)	
To B	Willia	n Craigh	ead				011:	ie Davis			
ì	19a. Informant	's Name/Relations						ber or Rural Route Num			(ip Code)
			/daughter					Springdale Date		20774 cation - City or	Town State
	4□Donat	2 ☐Cremation on 5 ☐ Other (m State I	rest H	osition (Name of matory or other place) ill Cemet	ery	4/25/2009 iiity J.B. Jen	Lyn	chburg,	VA
	1 X	of Funeral Service	1-hal		74	474 Lando	ver l	Road, Lando	ver,		5
ı	23a. Part1. En shock, or Immediate Car	heart failure. Lis	r omplications that t only one cause or	t caused the de n each line.	ath. Do not en	ter the mode of dy	ing, such a	as cardiac or respiratory			Approximate Interval Between Onset and Death
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Completed			· · · · ·					24a. Wa			utopsy findings available
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d	25. Was case	referred to medic	at				26. Pla	ce of Death (Check only			
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Certification:		ide deter	mined 26e. Fla	me		reet, factory, office		Spring	dale,	MD	ural Route Number, Lyrol Drive
Medical	29a. Certifier (Check on one)	y 2 ☐ Medica	I Examiner: On the and m	e basis of exam anner stated.	ination and/or in	nvestigation, in my	opinion, d		e, date and	d place, and due	e to the cause(s)
M	29b. Signature	and title of certifi	_	D, CRN	P		se numbe			te signed <i>(Mont</i> 24-0°	
	30. Name and	address of perso	n who completed ca			1,1,1			,		
	04 D. L. (1)	E JARELL				FOX LANE	SUIT	E 222 BOWIE	,MARY	LAND 2	0715
itate	31. Date filed	(Month, Day, Year		. Registrar's Sig	nature	FOX LANE	SUIT	E 222 BOWIE	,MARY	LAND 2	0715

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:20 AM 25, William Edward Bennett April 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Edgewater 318 Salisbury Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 X M 2 □ F 63 November 29, 1945 Cheverly, MD 217-44-5224 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, <u>the Medical Examinar mustos mothed at</u> 1 Tx Yes 2 □ No Director Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21037 318 Salisbury Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 Heating and Elementary/Secondary (0-12) College (1-4or 5+) Air Conditioning HVAC Division Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fill the and Mental H. 7 is marked oth Rosemarie Windsor William A. Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2600 Lady Annes Way, Huntingtown, MD 20639 William E. Bennett II / Son If item 27 or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Walnut Springs Cemetery 4/30/2009 Strasburg, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fungral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 rase Constance Approximate interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Year disease or condition resulting in death) a Lung Cancer /Medical Due to (or as a consequence of): Examiner 8 Years b. Orolaryn eal Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 2 □ No Ö 9 I Unknown <u>~</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>۾</u> 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 🛛 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation 1 🛛 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide 24 hours a Hospital 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/27/2009 D36371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Ernst Banfer, 3169 Braverton Street, Edgewater, MD 21037 32. Registrar's S State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygione

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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ation				1	Od. Inside City Limits
	e Mary la-f sh	ctor	Maryland Frederic	k	Freder	ick						XXYes 2□No
	th with the 23a or 28 ust by no	Funeral Director	10e. Street and Number 2500 Shelley Circ	le/Unit 3A			10f. Zip Code 21702	2		-	izen of What Cour	ntry?
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. The marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Marical Examinations to confine data	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☑ Note of the Property of the		If Yes, specify Cuban, Mexican, Puei 1 □Yes 2 💆 No Specify:			Specify Yes or No to Rican, etc.))-	14. Race - American Indian, Black, White, etc. Specify: Black	
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g	be filed tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)		-				me (First, Middle			
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Baltimore,			20a. Method of Disposition 1 TS Burial 2 □ Cremation 3 □ 1 TO Disposition 1 TO Disposition 1				tion (Name of itory or other place Mom Car	rd 4/28	Date /2009		ederick,	
a <u>t</u>	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of fluneral Service Licen		A.A.			ss of Facility St			•	
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~ I	Physician	2 1	23a. Part (Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that caused to one cause on each line	death. Do	not enter	W		c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	of):	ne car	na				years
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events	С.								
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VIII	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			3 🗆 DOA Othe		ath (Check only o			Hospice
0 1	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	2 ☐ ER/Ou	Time of	28c. Injur	v at	dome 5 ☐ Resi 28d. Describe I		MOther (Specia	House
SION	eath. or: Aft the fun	catio	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		rear)	njury	M 1 🗆	Yes 2 □ No				
	al or An s after d al Direct ed in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e, Place of Injur- building, etc.	/ - At home, fa (Specify)	rm, stree	t, factory, office		28f. Location (: City or Tox	Street an vn, State	d Number or Rura)	d Route Number,
	to the rospital or Attending Physician: The law require with 24 bours after debug. To the Funeral Director: After this certificate has been stompletely filled in by the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director.	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	yslclan: To the best of liner: On the basis of e and manner state	examination ar	e, death ond/or inve	occurred at the tirestigation, in my o	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	stated. the cause(s)
	To the company of the	M	29b. Signature and title of certifier				29c. Licens			29d. Dat	e signed (Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:17 PM 2009 Carolyn F. Ballou /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WICOMICO Salis bury Coastal Hospice at the Lake If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 10/18/1938 1 □ M 2 K F Director 135-30-6746 70 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a, State 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the medical Exercing must be notified at Director 1 ☐ Yes 2 X No Maryland Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21822 3325 Redden Ferry Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ballou Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse Health and Mental Hygiven 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marquerite Short ဂ William E. Waller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3325 Redden Ferry Rd. Eden, Maryland 21822 Joseph Ballou/husband permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/09 Salisbury, Maryland Parsons Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd. Salisbur 21. Signature of Juneral Service Lice e Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-trans and Physician: The law requires that the death certificate be exec Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy certificate perform 2 🗆 No 1 □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Hospital or Attending

State Registrar

(Check only one)

29b. Signat

(Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Po Box 1733 Sulisbury mo

HOSPICE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 7:24AM Brantner Paul Lerov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12511 Slider Lane Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jun 5, 1940 **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min 218-40-3114 Director 68 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Medical Evanimur must be notified at MD Allegany Cumberland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 Race Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 🏝 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operating Engineer Local 37 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other I any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy J. Brantner Vivian (Kelley) Brantner ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1153 Frederick Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Ruth Brantner daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Addressi of Turieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part f. Enter the lisea e, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h-prt failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final disease or cond in resulting in death) **Physician** str a Meto 07-11-2005 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending phate as the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? 1 □ Yes 2 🔼 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 5 \subseteq Residence 1 ∏Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1) Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0013

DHMH 17 Rev 1/2001

Dr

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1- State RegistrarAMEND#10abc, perFH, 4/27/09, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 4:45P M Peter Chan 2009 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Casey House- Montgomery Hospice Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 578-80-4058 71 Director China DEC. 19. 1937 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State or items 23a or 28a-f show event, the Medical Examiner must be notified at District of Columbia 1X Yes 2 □ No Director Washington, DG None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America 20001 #802 800 6th Street NW Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, If at Musical Education. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Woon Ching Ip Tai Fai Chan ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18564 Cape Jasmine Way, Gaithersburg, MD 20879 19a. Informant's Name/Relationship (Type. Print) Yung Chan - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)* George Washington Cem. 04/26/09 Adelphi, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service L JA Will 11800 New Hampshire Ave. Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liver Malignancy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate sause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Hepatitis B Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2♣ No 24a. Was an autopsy performe 1 □Yes 2 DNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐ Yes 2. 🛣 No Other: 4 \(\text{\text{Nursing Home}}\) 5 \(\text{\text{Residence}}\) 6 \(\text{\text{Mother}}\) Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death

Director: A 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in 29a, Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Koucetcher, my 20063748 April 24, 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Md 20854 Jocelyne Kouatchou, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

27

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 1, 2009 0848 hrs **Medical Examiner** Shari Lee Cochran 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bethesda Montgomery Suburban hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 06/22/1961 Country)Virginia 225-11-5778 M 2 X F 47 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 Yes 2 X No Fairfax VA Centreville death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 5887 Clarendon Springs Place 20121 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: Caucasian 4 X Divorced Yes 2 X No specify: f Yes, Give Year Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other than the Medical Baltimore, MD 21215-0036 12 Insurance Agent Insurance 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Dale Cochran Enid Virginia Bachman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 1 2 1 If item 27 is n ther traumatic Tyler Lautenbach - Son 5887 Clarendon Springs Place Centreville VA 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baker-Post Cremation Ce Burial 2 X Cremation 3 Removal from State 5/11/09 Manassas, Virginia Center Other Specify 21. Signature of Funeral Service Lice 22. Name and Address of Facility Baker-Post Funeral Home CC0424 10001 Nokesville Rd. Manassas, VA 20110 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac Arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and trat Physician/Medical AMENDED 23a,27 per me g892 6-11-09 vt X UNPENDED attending physician for use as the burial Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown ned by the The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ Yes 2 No 3 Probably 4 ✓ Unknown Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical Be Hospital: 1 Other, Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 Yes 28a. Date of Injury (Month, Day,Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Pending Yes 2 No Director: d in by the f 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) To the Funeral L completely filled determined 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4 DENO May 2, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day Year) Registrar's Signatu State

Registrar

09-03352 Ric

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2009 15065

cha	rd Gene C	ain		For State of Maryland / Department of Fleath and Maryland / Department of Fleath / Department		eg. No.	L U	07 1000
	Physic	ian/		oistrar Decedent's Name (First, Middle,Last)	2. Date of Dea Month April 26,	Day `	/ear	3. Time of Death 1142 hrs
e-	Exam	iner		Richard Gene Cain a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. Coun	ty of Death	
			48	5800 Sunnyside Avenue Beltsville		Prince George's Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign		
	Funeral		5.	Social Security Numbet 1kn 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	-		Cou	ntry)
	Director			1XM 2 F 67 Yrs.	04/	01/42	wes	st Va
	any		_	Sual Residence of Decedent				10d. Inside City Limits
9	*	_		Md Prince George College Park				1 X Yes 2 No
5	Maryland 28a-f show d at once.	Director	10	0e. Street and Number		10g. Citizen of USA		try?
1	215-0036 be filed within 72 hours after death with the Maryland nutal Hygiene. **rided other than "unatural", or items 23a or 28a-f she contined at once.	ة		5023 Paducah Road 20740 1 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or N			can Indian, Black,
_	ath wit items?	Funeral	1	1. Marital Status 1. Married 12. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Married 1. Yes 2. No	Rican, etc.)	l v	vhite, etc. Wh	ite
	fter de l'', or	by Fu	٠ I	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	week done	Spec	ify: of Business/li	
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	5-0036 Hed within 72 Hygiene. I other than "the Medical I	11 0	ן י	17. Father's Name (First, Middle, Last)	ne (First, Middle Cain	e, Maiden Surn	ame)	
	21215-0036 build be filed within 7 Mental Hygiene. marked other than	8		Herbert Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of		lumber, City or	Town, State	, Zip Code)
	Sho and and 7 is	}	- 1	Georgette H. Cain Daughter 9200 Edwards Way	#214	Adelp	hi, l	Md 20783
	ore, M es 1 and 2 of Health If item 2		2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 5 / 0.4 / 0.	9 Riv	erda.	le, Md
	Pages nent of ant: I			A Departion 5 Other Specify				
	Baltimore, permit. Pages 1 at Department of He Important: If ite	r i	2	22. Signature of Funeral Service Licensee 22.3 Page and Admon Fully and 1409 Fairlakes	Serv PlSt	e B M	itche	llville,MD
	Physicia		1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac				Approximate Interval Between Onset and
	/ledica	al		failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Diphenhydramine and salicylate int</u>	oxicati	on		Death
	-Xaillille			or condition resulting in death) Due to (or as a consequence of):				
		3		Sequentially list conditions, if at y, leading to immediate Due to (or as a consequence of):				
۸			E١	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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	876 tificate ng phy	as the t	Ě	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant of the past 12 months?	gnancy	Mo	onth	Day Year
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	D. Be the de by the	iched f	됩	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				o the cause of death?
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5	ision of Vital Records, P.O. Attending Physician: The law requires that th reath. reteath.	eral dir	<u>۽</u>	1 ✓ Yes 2 No Imparent 2 Enterth 28a, Date of Injury 28b, Time of Injury 28c. Injury at Work?	28d. Desc	ribe how injury	occurred g	ubject rdosed on
	On C ending ath.	the fun	틽	1 Natural 5 Pending Fd 4/26/09 Fd 11:15 am	hwar-	the-cor	inter	medication
	Division tal or Attendins after death.	in by	Certification:	3 X Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locat	wn, State) 58 sville	300 Su	Rural Route Number, City nnyside Ave
	Di ospital hours a	y filled		4 Homicide determined (Specify) Woods 29a. Certifier (Check paly 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and	manner as s	tated.
	Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the	npletel	Medical	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	red at the time,	uate and place	, and a	
4	To To To	COL	Mec	29b. Signature and title of certifier 29c. License number			ate signed (i 27, 2009	Month, Day,Year)
				Mhr Brassly, Mid O.C.M.E.		April		
		оси	1E	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, I	MD 21201			
		Str	ate	Wellsau Diason, We				
	Re	gist		31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature & January 1.				

09-03136 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Herbert A. Callihan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 19, 2009 Herbert A. Callihan 1527 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5225 Pooks Hill Road Apt. 1129S Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign North Carolina
Country) Months Days Hours Director 8/16/1933 241-50-5649 1 X M 2 75 Yrs Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No e notified at once. 28a-f show Maryland Montgomery Bethesda Itimore, MD 21215-0036

It. Pages I and 2 should be filed within 72 hours after death with the Maryland rment of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5225 Pooks Hill Rd., Apt. 1129S USA 20814 Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 1 X Yes No Divorced If Yes, Give Year 1956-60 3 X Widowed Specify: 1 Yes 2 X No specify: White "natural", ۵ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical nt: If item 27 is marked other than Law Attorney 5+ vears 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Aldon Callihan, Sr. Catherine Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Liz S. Callihan/ Daughter 6105 Benalder Dr., Bethesda, MD 20816 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 Removal from State crematory or other place) Important: I injury or othe 4/22/09 Edgewater, Maryland Kalas Crematory Donation / Other Specify: 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatura Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical y the attending physician hed for use as the burial -UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 Unknown death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ 1 Yes 2 No 3 Probably 4 V Unknown Chronic Alcoholism Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has death? performed? ✓ Yes 2 1 🗸 2 No 25. Was case referred to medical 26.Place of Death (Check only one) director, Be Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 Pending Director: filled in by the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) within 24 hours a To the Funeral L determined (Specify) Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) April 20, 2009 O.C.M.E.

Laron Locke MD. 31. Date filed (Month, Day, Year) State Registrar

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who mp eted cause of death (Item 23a)

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exeminations to rofficed at once.

Physician
/Medical
Examiner

Physic /Med Exami

Funera Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	_ FOI	•	epartment of Health ar	nd Mental Hyg	giene										
	1 - State Registrar		Certificate of Death		Reg. No. 2	9 1506									
	1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ath Day Year	3. Time of Death									
an al	Ebba Norman Cappelen			04-19		6:15P₩									
er	4a. Facility Name (If not institution, give street and number,	.)	4b. City, Town, or Location of	Death	4c. County of De										
	Sunrise Assisted Living	Anne Arundel													
		ge (In yrs. last birth	Annapolis oday) If Under 1 Year If Under 24	Hrs. 8. Date of Birt	9. Birthplace (State or Foreign										
	097-07-2688 1 ☐ M 2 基底	92 Y													
'n	10a. State 10b. County	10c. City, Town	10c. City, Town or Location												
Director	Maryland Anne Arundel	Annapo			10 000 (1100)	1 √ Yes 2 No									
	10e. Street and Number		10f. Zip Code		10g. Citizen of What 0	country :									
Funeral	1728 Woodlore Road		21401		USA										
nue	11. Marital Status 12. Was Decedent Armed Forces:	Ever in U.S.	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.									
	1 X Never Married 2 Married 1 Yes 2 X If Yes, Give	•	1 ☐ Yes 2 ☑ No Specify:		Specify: White										
Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		***												
ete	15. Decedent's Education (Specify only highest grade completed)	i i	Decedent's Usual Occupation (Give kind of work done during most o	of workina I	16b. Kind of Busines	s/Industry									
du	Elementary/Secondary (0-12) College (1-4or 1 2	E.)	life. DO NOT use retired) sonnel Superinten	-	U.T. Coont	C									
Ö		1 61;		W.T.Grant Company											
To Be	17. Father's Name (First, Middle, Last) Thorvald Cappelen			s Name <i>(First, Middle,</i> rid Norman											
_	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street and Number	or Rural Route Numbe	er, City or Town, State	, Zip Code)									
	Jerry Farrell & Sherry Ne	ice :	1728 Woodlore Roa	d, Annapol	is, Md 214	01									
	20a. Method of Disposition		Disposition (Name of crematory or other place)	Date	20c. Location - City of										
	1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State	'	i	10010000											
	4 Donation 5 Other (Specify)	Huntt (Crematory 4.		Waldorf, M										
	21. Signature of Funeral Service Licensee				. Evans Fu										
	[MXII]		16000 Annapolis												
	23a. Part 1. Enter the disease, complications that cause shock, or heart failure. List only one cause on each I	d the death. Do no line.	ot enter the mode of dying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death									
	Immediate Cause (Final														
	disease or condition resulting in death) a. Coolia C Try Imm (a.) Due to for as a consequence of:														
			,												
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):														
ᆵ	cause. Enter Underlying Cause (Disease or injury that initiated events c														
Examiner		s a consequence of	f):			1									
<u>a</u>	resulting in death) Last Due to (or as a consequence of):														
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Me	IF FEMALE: 23c If yes, outcome	e of pregnancy													
ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth	2 Fetal death			23d. Date of o										
sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 2 □ University		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of c	delivery Day Year									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** EE CRUMP Li 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake House Linthicum Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 6, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. CA CA 1 ☐ M 2 🗷 F 1928 573-32-0685 80 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Experiment must be notified at 1∭Yes 2 No Director MD Prince Georges Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 11501 Duckettown Road USA Funeral death y Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black Specify ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) Clerk Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Allen Bettie Jackson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Brenda Stringer/ Daughter 11501 Duckettown Road Laurel, MD 20708 20b. Place of Disposition (Name of cametery, crematory or other place)
Forest Lawn
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/25/2009 Hollywood Hills, CA 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Servi 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician an disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 7 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 □Yes 2 🗆 No 1 □Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 □Yes 2 □No 2 Accident investigation the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

DHMH 17 Rev 1/2001

29b. Signature and title of certified

Name and address of person who completed cause of death (Item 23a) (Type, Pript)

M. 441

Registrar's Signature

ate signed (Month, Day, Year)

EFENSE HaHWAY ANNAPOLI, MDZIVO,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009

			1 - For State Registrar	State of Maryla		artment of F rtificate of I		R	leg. No. 2	009	15069
	Physici	an	1. Decedent's Name (First, Middle, L MICHAEL	.ast) CURR	Y			2. Date of Dea Month APRIL	th 21	2009	3. Time of Death 4:15 A M
war.	/Medio		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death		_	unty of Death	4.13 A
angel "			PRINCE GEORGE'		- 14 hindh dau ()	CHEVERI	LY If Under 24 Hrs.	P Date of Birth			ORGE 'S
ı	Funeral Director		5. Social Security Number 6. 579-76-1605	Sex 7. Age (In your 1	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day DEC 9	, _{Year)} L957	WASH	place (State or Foreign ntry) IINGTON, DC
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	e Mary Ba-f sh Ilifiou	ctor	MD PRINCE	GEROGE'S	BLADEN	ISBURG					1X Yes 2 □ No
	with the	Director	10e. Street and Number	TH AVENUE Apt	135	10f. Zip Code 20710			10g. Citizen USA	of What Cour	ntry?
9	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, The Marical Everting to us to be natified at	/ Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White, ecity: BLA	etc.
Maryland 21215-0036	72 hours natural", Jical Eve	eted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest g	Year or Dates:	16a, Dece	dent's Usual Occup	ation	ina		of Business/In	
2121	/ithin han han	Completed	Elementary/Secondary (0-12) 9th	College (1-4or 5+)	life.	kind of work done of DO NOT use retired STOCK	1)		PRI	VATE	
gue	2 should be filled w n and Mental Hygie is marked other t raumatic event, In	Be	17. Father's Name (First, Middle, Last JOHNNIE JOHN				18. Mother's Nam	e (First, Middle,	Maiden Sur	name)	
aryl	s 1 and 2 should be if Health and Mental item 27 is marked other traumatic ev	으	19a. Informant's Name/Relationship		19b. Mailin	ng Address (Street			r, City or To	wn, State, Zij	o Code)
	1 and 2 Health a em 27 is ther tra		LILLIE WRIGHT							<u>- </u>	AND 20774
Baltimore,	Pages 1 nent of H int: If ite iry or ot	I	20a. Method of Disposition 1	Li hemovar from State		osition (Name of matory or other place	1	Date		on - City or To	
altir	permit. Pages Department of Important: If it any Injury or once.	ď	21. Signature of Funeral Service Liq		IERITAGE 22	MEMORIAI Name and Addre	on of English	1/2009∣ J. B. JE			
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1	Physician /Medical	5 (3	23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each line. a. P. Po T. Due to (or as a cons	malier	,	mic ula				Interval Between Onset and Death
	ifficate be executed xx g physician and as the burial-transit as	Examiner	Sequentially list conditions, that, to an action of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
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O. Box	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ For 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у		23d.	. Date of deliv Month	rery Day Year
rds, P.	quires that en signed b uld be deta	ρ	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.			contribute to t lo 3	the cause of death?
	The larate has	Completed						24a. Was a autop: perfor 1 ∐Yes		4b. Were auto prior to co death? 1 □Yes	opsy findings available ompletion of cause of
VItal	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital: 1. Inpatient 2	□ EB/Outpation	ot 3 DOA Oth	26. Place of Dea		(Check only one) e 5 Residence 6 Other (Specify)		
n of	iding Physician: th. : After this certifica : funeral director, p	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o			28d. Describe h		, ,	19)
Division	r Attendi ter death. irector: A ire by the fu	ertification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Injury At	t home, farm, str	M 1□	Yes 2□No	28f. Location (S City or Tow	treet and North, State)	umber or Run	al Route Number,
2	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Cer	(Check only 2 Medical Ex	Physician: To the best of my laminer: On the basis of exam	knowledge, deat ination and/or in	h occurred at the tile evestigation, in my c	me, date and place	, and due to the or	cause(s) an date and pla	d manner as	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	29d. Date si	igned (Month,	Day, Year)
	Ì.		1 Karen	Brook		800	42183	2	4/6	1109	
	BI	. 9	30. Name and address of person wh KAREN BROOKS M				NIY. MARV	I.AND 20	785		
Ĺ	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig		OHEVER	er s reserve		,,,,,		

DHMH 17 Rev 1/2001

			Pleas	se Type or Pr							•	
		For State Registrar		State of N	rarylari		ertificate c		and Mental H	ygieri Rea. N	-2 n n a	15070
		1. Decedent's Name	e (First, Middle,	Last)					2. Date of I			3. Time of Death
Physicia /Medic		CALEB	J						20,	2009 Year	7:37 PM	
Examin		4a. Facility Name (If not institution, give street and number)					4b. City, Town	n, or Location of		4c. County of Death		
<i>?</i>				ORIAL HOSPI				DERICK			FREDERI	
Funeral		5. Social Security No		6. Sex 7. A 1 X M 2 ☐ F		last birthday Yrs.	Months Da		Min. (Month,	Day, Year	r) Co	thplace (State or Foreign ountry)
Director		215-27-11 Usual Residence of	_		24	110.			Aug. I	7, 1	.984 Mar	ryland
yland now		10a. State	10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
eath with the Marylan ns 23a or 28a-f show must be notified at	cto	Maryland	Frede	erick	M	t. Aiı	· y					1 □Yes 2K∑No
ith th	Director	10e. Street and Num					10f. Zip Cod			10g. C	Citizen of What Co	
ath w	iral		ove Dr					1771				States
items items	Funeral	11. Marital Status 1 X Never Marrie	od 2 Marris	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑	?	5. 13.	If Yes, specify C	uban, Mexican	gin? (Specify Yes or f n, Puerto Rican, etc.)	NO-	14. Race - Ame Black, White	
filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Marical Examinat must be publised at	by	3 ☐ Widowed		If Yes, Give Year or Dates			1 □Yes 2XI	No Specify:			Specify: W	hite
72 hou	Completed	(Spec	15. Decedent's	s Education grade completed)			edent's Usual Oc		t of working	16b.	Kind of Business	Industry
ithin 7	nple	Elementary/Secon		College (1-4or	5+)	life.	DO NOT use rei	tired)	to working			•
led w Hygier her ti		12	(Einst Middle I	not)		<u> </u>	Auto Det		er's Name (First, Mida		Automobi	Te
t be fi	To Be	17. Father's Name (ebra S. Del		iii Surname)	
should nd Me mark matk		19a. Informant's Na				19h Mail	ing Address (Str		er or Rural Route Nun		or Town, State	Zin Code)
nd 2 salth ar		Debra S.					Dove D		Mt. Airy,	-		
s 1 a of Hea Item		20a. Method of Disp	osition	<u> </u>	20b. P		osition (Name of ematory or other		Date		Location - City or	
Page nent c int: If		1 ☑ Burial 2 ☐ 4 ☐ Donation		3 □ Removal from Stat <i>ecify)</i>	9		e Cemete		April 24, 2009	Mt	. Airy	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exagine.		21. Signature of Fu	peral Service L	icensee					y Stauffer			
207 2 2		18/	200)		8	E. Rid	geville	Blvd. Mt	. Ai	ry, Mary	land 21771
										Approximate Interval Between Onset and Death		
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w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medica	IF FEMALE:		23c. If yes, outcom	e of pregna	incv					001 Data of da	
atten for u	cian	23b. Was decedent in the past 12 r	months?	1 ☐ Live birth	2 Feta	I death 3	☐ Ectopic pregn ☐ Other <i>(specify</i>				23d. Date of de Month	Day Year
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s that gned b	by P	Part II. Other signifi	icant condition	ns contributing to death	but not resu	ulting in the o	underlying cause	given in Part I.	23e. Die	d tobacco	use contribute to	the cause of death?
equire en sig	edi	Depression 1 Yes 2							2 № No 3 🗆 P.	robably 4 🗍 Unknown		
law r las be	Completed	Co	cain	e De	Per	nde,	1ce		24a. Wa	topsy	prior to	utopsy findings available completion of cause of
cate h	Sol				0				pe 1 □ Yes	rformed? 2 Z N	death? lo 1 ☐ Yes	2 No
certifi ector	Be	25. Was case referrence examiner?		Hospital:	*-/			26. Place	of Death (Check only	y one)		
Phys r this ral dii	၉	1 Yes 2 ☐ I		1 ☐ Inpa	\rightarrow	ER/Outpatie	IN 3 LI DOA	njury_at	ursing Home 5 ☐ Re 28d. Describ			ecify)
nding th. : Afte e fune	ation	1 ☐ Natural 2 ☐ Accident	5 Pending investiga	ation And 20	ay, Year)	Injury	~ V	Vork? □Yes 2 ∑		- 2	1 10	in head
er decretor	Certification:	3 Suicide 4 ☐ Homicide	6 ☐ Could no determin	. a Zoe. Flace of the	njury - At ho	ome, farm, st	reet, factory, office	oe .	28f. Location	(Street a	and Number or Ri	ural Route Number
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Hosp 4 hou Funer tely fil	Medical	(Check only		Physician: To the bes xaminer: On the basis	of examina							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buring the purification.	Med	29b. Signature and t	title of certifier	and manner	stated.		29c. Lic	ense number		29d. D	ate signed (Mont	th, Day, Year)
F S F O		1 00	1 6	Dan MI	2 7	11:	D.	27107			.1 00	2000
1	}	30 Name and addre	ess of person w	no completed cause of	death (Item	23a) (Type	Print/	37197				2009
3 S		Han Koll 31. Date filed (Month	rev. M.	DDME	trar's Signa	st 7	Stre	et, F	rederick	M	D 21	701
Sta Registra			PR 27		was signa	1. 4	arke		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 0638 PM Leon W. Cross 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO COASTAL HOSPICE AT THE LAKE ALISBUR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/16/1936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 🗆 F Months 219-34-3565 73 Delaware Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State ? Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examir or must be notified at 1 ☐ Yes 2 No Director DE Sussex Seaford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28297 River Road 19973 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 🗌 No 1 ☐ Yes 2 ☑ No Specify Specify: White 2 3 Widowed 4 Divorced 958 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ind Mental Hygiene. Manufacturing Pipe Fitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent F. Cross Elizabeth Wallace ပ permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 Is mark any injury or other traumationce. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Cross / Wife 28297 River Road, Seaford, DE 19973 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bridgeville Cemetery | 04/24/2009 | Bridgeville, DE 22. Name and Address of Facility
Parsell Funeral Enterprises, Inc. 21. Signature of Funeral Service Ligens 202 Laws Street, Bridgeville, DE 19933 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ind /Medical Due to (or as a const que ce f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Month in the past 12 months? Year Day Pregnant at time of death 5 ☐ Other (specify) 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence e Other (Specify) Hospital: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide

P.O. Box 68760, Division of Vital Records,

Maryland 21215-0036

Baltimore,

within 24 hours after death.

To the Funeral Director: After this certific Medical State

4 ☐ Homicide

(Check only one)

29a. Certifier

and manner stated.

29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Coastal Hospice Po Box 1733 Salisburym

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental H 1 - State Registrar Certificate of Death	lygiene Reg. Ng2 0 0 9 1 5 0 7 2
			1. Decedent's Name (First, Middle, Last) 2. Date of I	
н	Physicia /Medic		Coorgo Downs	M
-14-1	Examin		A Figure At the state of the st	4c. County of Death
-			Anne Arundel Medical Center Annapolis	Anne Arundel
	Funeral			Day, Year) Country)
	Director		214-32-8759 //2 March	n 7 1937 Maryland
	and		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	10d. Inside City Limits
	Maryl f sho	ò		1 ⊡XYes 2 ⊟ No
	the 28a	Director	Maryland Anne Arundel Annapolis 10f. Zip Code	10g. Citizen of What Country?
	3a ol			TISA
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
Q	after or ite	교	Armed Forces? 1 ☐ Yes 2 ☒ No 1 ☐ Yes Give 1 ☐ Yes 2 ☒ No Specify:	Specify: Black
215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show froil Evoi. Inc. out be notified at	d by	5 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	
5-	72 h "natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/Industry
12	within lene. than "	E G	Elementary/Secondary (0-12) College (1-4or 5+)	
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an	Duld be f Mental I arked of atic eve	Be	ži – i – i – i – i – i – i – i – i – i –	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Hammatic e	မ	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num	
ĕ S	1 and 2 s Health ar tem 27 Is			polis. Md. 21403
ē,	es 1 al of He of He of item or othe	-	20a. Method of Disposition 20b. Place of Disposition (Name of Date cameters of their place)	20c. Location - City or Town, State
Ę	Page lent c nt: If ry or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Hill Crest Cemetery 4/24/09	Annapolis, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importament of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any hojury or other traumatic event, the indical Erds. Indical Erds. Indical any once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 821 Wes	st St. Annapolis, Md
Ď	permi Depar Impor any Ir		Jany 12. Reese Moot83 Wm. Reese & Sons Mor	ctuary, P.A.21401
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.	Interval Between
	Physician		Immediate Cause (Final disease or condition Personal Carly	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	115000
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
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687	ficate physis the	gi	d	
Box	leath certifica attending ph for use as th	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
ă	death e atte	Physician/Med	25. Was decembly regnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)	Month Day Year
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<u>=</u>	The cate h	Completed	pe 1 □ Yeı	erformed? death? s 2 No 1 □Yes 2 □No
Vital	ysiclan: The lis certificate hidirector, page	Be	25. Was case referred to medical examiner?	ly one)
of	Phys this al dir	유	Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 R. Proposition Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 R. Value of Injury 28b. Time of 28c. Injury at 28d. Descrit	esidence 6 Other (Specify)
'n	ding Ph. h. After thi funeral	ioi	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at 28d. Described 28d. D	be how injury occurred
<u>is</u>	I or Attendi after death. Director: A in by the fu	ical	2 Accident investigation M 1 Lives 2 Live 1 Section 2 Section 1 Lives 2 Live 2	n (Street and Number or Rural Route Number,
Division	after Direction by	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be determined 6 ☐ City or 1 ☐ City or 2 ☐ City or 2 ☐ City or 3 ☐ City	Town, State)
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			
	ne Ho n 24 h ne Fui	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tine one)	me, date and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
			Janua wenn, 1111) DSLYSO	1721/20,0007
	10W		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerinne USEVNEV, MD GDDBB to GER Rd	1772112-, 2009 #300, Angapolis, MD 2140
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 7:00 AM April 26 Earl L. Dammyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard 2863 Country Lane Ellicott City If Under 1 Year | If Under 24 Hrs. 6. Sex. 1 2 M 2 □ F 8. Date of Birth (Month, Day, Year 9/26/1917 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Months MD Director 213-03-8275 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ortant: If them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Ellicott City Howard 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21042 United States 2863 Country Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 🔏 No 9 Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive onould be filt.
Ith and Mental Hv.
7 is mark. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Daily Charles Dammyer ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is.
any Injury or other train 2863 Country Lane Ellicott City, MD 21042 Darlene Grund - daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Ardent Cremation 4-27-2009 Hanover, MD 21. Signatura Funeral Se vice Licensee M01411 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 to 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 Smonth /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if a p, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. and Due to (or as a consequence of) burial-Box 68760, physician that the death certificate be Physician/Medical the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Port in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2□No P.O. the 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No certificate e Hospital or Attending Physician: 24 hours after death.
e Funeral Director: After this certifica letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **□** No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. the To the within ? 29d. Date signed (Month, Day, Year) 29b. Signatur 30185

800

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

Load, Suite 210, Cutmsville, MD 21225

erson who completed cause of death (Item 23a) (Type, Print)

405 Frederic

			For State	State o	f Maryland		artment o rtificate d			de ntal 1	Hygier Reg. I	20	09	15074
			Registrar 1. Decedent's Name (First, Midd)	lle, Last)						2. Date o	f Death			3. Time of Death
	Physici		Frances El	izabeth	Dark-Wh	ite				Month		Day 200	Year)9	5:16 P M
	/Medio		4a. Facility Name (If not institution	on, give street and nur	mber)		4b. City, Tow	n, or Locatio	n of Death			4c. County		, , , , , ,
-	- According		Washington Ad	lventist Ho	ospital		Takom	a Park				Mont	gomer	у
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Ye			8. Date o	f Birth n, Day, Yea	ar)	9. Birth	place (State or Foreign
	Director		579-40-7139	1 □ M 2 X F	80	Yrs.	Working Do	.,,		May		928_	1	h Carolina
	pu »		Usual Residence of Decedent 10a. State 10b. County	,	10c City	. Town or Lo	cation						1.	10d. Inside City Limits
	sho	5		gomery	1 1	•	Spring							1 X Yes 2 □ No
	the N 28a-1	Director	10e. Street and Number	Somer y		TVCI	10f. Zip Cod	le .			10a.	Citizen of	What Cou	ntry?
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21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examinations be calified at	by Funeral	1 □ Never Married 2 □ Mai 3 □ Never Married 2 □ Mai	rried Armed Fo	rces? 2000 Vertical		Was Deced <i>e</i> nt If Yes, specify (1 □Yes 2 🕇			o Rican, etc	.)	Specia	ick, White, fy: A	^{etc.} African merican
ŏ	2 hou	Completed	15. Deceder	nt's Education		16a. Dece	dent's Usual Oc	cupation	oct of wor	kina	16b	. Kind of B	Business/In	dustry
218	be filed within 72 ho ital Hygiene. id other than "natui event, Ire Medical	ed ((Specify only night	est grade completed) College (1	-4or 5+)		kind of work do DO NOT use re		ost of wor	King		C-16	E 1	a.v.a.d
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yla		၉	Edward Butle	er						Anth				
Maryland	s 1 and 2 should be fi f Health and Mental I item 27 is marked of other traumatic eve		19a. Informant's Name/Relation		•		ng Address (Str					•		
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Baltimore,	permit. Pages 1 ar Department of Hes Important: If item eny Injury or othe once.		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		State For	emetery, crer	sition (Name o natory or other coln Ce	place) metery	и Мау	2, 20	009		twood	
Balt	permit. Depart Import eny Inj		21. Signature of Funeral Service	- house	0/10	11	2. Name and Ad 001 Ben							
			23a. Part 1. Enter the disease, of shock, or leart failure. Lis	or complications that c	aused the death.	. Do not ent	er the mode of	dying, such	as cardiac	or respirate	ory arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	polania									Onset and Death
	/Medical		resulting in death)	Due to	or asia consequ	ence of):	7 . 1							
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8760,	icate be executed physician end s the burial-transit	dica		d										
9 ×	Physician: The law requires that the death certific this certificate has been signed by the attending print director, page 2 should be detached for use as	Physician/Medical	IF FEMALE:	23c If yes out	come of pregnar	ncv						224 D	ata af dalis	1071
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 poinths?	1 ☐ Live I	birth 2 Fetal	death 3	☐ Ectopic pregr ☐ Other (specif						ate of deliv Ionth	Day Year
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	res that the de signed by the a be detached		Part II. Other significant condit	ions contributing to de	eath but not resu	Iting in the u	nderlying cause	given in Pa	rt I.	23e.	Did tobac	co use cor	ntribute to	the cause of death?
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Division of Vital Records,	w requir s been s should	Completed									Was an	24b	. Were aut	opsy findings available
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>	ysici is ce direc	To B	examiner? 1 ∐ Yes 2 DNo	Hospital: 1	Inpatient 2 🗆 E	ER/Outpatie	nt 3 DOA	Other: 4 🗆	Nursing H	lome 5	Residence	e 6 🗆 O	ther (Spec	ify)
0	ng Pt fter th	Ë	27. Manner of Death 1 Satural 5 ☐ Pendi	/Allon	of Injury th, Day, Year)	28b. Time o	f 28c.	Injury at Work?		28d. Desc	ribe how i	njury occu	rred	
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<u>≅</u>	r Att ter de lrecte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 28e. Place	of Injury - At hor ng, etc. (Specify	me, farm, str ')	eet, factory, off	ice			ion (Stree r Town, S		ber or Ru	ral Route Number,
Ω	ital or ral D		—											
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medica one)		asis of examinat ner stated.	tion and/or in	vestigation, in	my opinion, o	death occu	irred at the	time, date	and place	, and due	to the cause(s)
		Σ	29b. Signature and title of certific	or MD			29c. Lic	ense numbe	MI		29d.	Date sign	ed (Month	Day, Year)
	3		10000	1 1-2			D	000	1)		H	pnl	17	200 1
_	B		30. Name and address of person M 13 A R A L 31. Date filed (Month, Day, Year	who completed caus	se of death (Item 7616Cか	23a) (Type, RL bL	LAVE,	STET	340,	TAKO	MAP	HR1C	-, M	D20912
	Sta Registi	ile	31. Date filed (Month, Day, Year APK 2 & ZUUS	Server 32. F	Registrar's Signat	ure								

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:38 a ^M April 22, 2009 Donald Thomas Groves, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days **XX** M 2□ F 81 216-22-6702 Jan 22, 1928 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evantinat must be restlined at 1 ☐ Yes XX No Director Augusta Hamoshire 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 26704 HC 78 Box 87CC Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give 1945–46 Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filled within 72 lith and Mental Hygiene. 27 is marked other than "n: raumatic event, Inc Medi College (1-4or 5+) Elementary/Secondary (0-12) Railroad Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Groves Eva Beeman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tra once. Health a 618 Greenbrier Drive, Silver Spring, MD 20910 Louise D. Groves /Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory April 27, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARAI Physician disease or condition resulting in death) /Medical Examiner HYTHMIA Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, OBSTRUCTIVE PULMOPAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page GASTR 1 ☐Yes 2 ☐No 1 ☐Yes 2X No **Division of Vital** 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Dath 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 🛛 Natural 5 Pending investigation n 24 hours and, he Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Y KIEGUT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MH 6420 Rockledge Dr, Bethesda, MD 20817 Iserny Kreutz, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Trowes, Donald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:42 P M 16, 2009 April Margalee Corcoran Gillette /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carriage Hill Bethesda Montgomery Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Days Min 1 □ M 2 □ F 91 266-26-0664 3-18-1918 Florida Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2X☐No MDMontgomery Chevy Chase Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4701 Willard Ave #313 USA 20815 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify:White 1 ☐ Yes 2 ☐ No Specify ۾ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerite Pace Arthur A. Corcoran ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gillette Spouse 4701 Willard Ave #313, Chevy Chase, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 9,2009 Arlington Arlington National . VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions Due to (or as a consequence of): flary leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiomyopathy Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation Myocardial Infarction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death

Physician /Medical Examiner The law requires that the death certificate be executed

Funeral

Director

works

ntal Hygiene. ed other than "natural", or items 23a or 28a-f shove event, the Modical Examinant or the confined at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other: any Injury or other traumatic event, III

within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

Physician:

Exami Physician/Medical \$ Completed

sician and burial-transit aftending physician for use as the buria signed by the a ns certificate has been s director, page 2 should To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir this Certification:

1 📉 Natural

2 Accident

4 Homicide

3 Suicide

28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 6 ☐ Could not be

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifi

D35579

29c. License number

29d. Date signed (Month, Day, Year) 4-21-2009

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

8218 Wisconsin Ave. Suite 305 Bethesda, MD 20814 Susan J. Miller

State Registrar

Medical

31. Date filed (Month, Day, Year) 27 APR



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15077

Baltimore, Maryland 21215-0036

1 - For State Registrar

Division of Vital Records, P.O. Box 68760,

		1. Decedent's Name (First, Middle,	Last)					2	 Date of Dear Month 	th Day	Year	3. Time of Death
Physicia		Harold Albert G	æll. Jr.						April			6:00 A ^M
/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location o				ounty of Death	
Examin	ier	13720 Lockdale				Silver S					tgomery	7
				e (In yrs. la	st hirthday)	If Under 1 Year			Date of Birth	_		lace (State or Foreign
Funeral			1 □XM 2 □ F		14	Months Days	Hours	Min.	. Date of Birth (Month, Day	Year)	Cour	ntry)
Director		338–26–1352 Usual Residence of Decedent		/	6 Yrs.				eb 25,	1933	3 Illir	1015
and		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
sho	5											1 ∐Yes 2 X ∏No
Ba-f	3ct	MD Montgo	жегу	SIIV	er Spi					0.00		
if the	Ö	10e. Street and Number	D 3			10f. Zip Code					n of What Cour	itry?
23a	Funeral Director	13720 Lockdale	Road			20906				USA		
ems dea	ıne	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. \	Was Decedent of H	lispanic Ori	igin? (Speci	fy Yes or No- can, etc.)	14.	. Race - Americ Black, White,	
or it		1 Never Married 2 Marrie	ed 1 Maryes 2 □ 1 If Yes, Give	No		I∐Yes 2∭XNo			,	e,		
ral",	l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1950-	54	- 100 грдио	ороспу.			36	pecify: Whi	rte
2 hc	Completed	15. Decedent's	s Education		16a. Deced	dent's Usual Occup	ation	t of working		16b. Kind	of Business/In	dustry
hin 7	ğ	(Specify only highest Elementary/Secondary (0-12)	T	5+)		kind of work done DO NOT use retired		e or working	1			
r the	υo	2.0.1.0.1.2.7	College (1-4or 5		Patent	t Attorne	ey.			Law F	irm	
Hy othe ent,	Bec	17. Father's Name (First, Middle, L	.ast)				18. Mothe	er's Name (First, Middle,	Maiden Su	ırname)	
d be enta ked c ev	To B	Harold Albert G	æll, Sr.				Iven	ell W	esner			
mar mat	-	19a. Informant's Name/Relationshi	in (Type Print)		19h Mailin	ng Address (Street	and Numbe	er or Rural i	Route Numbe	r. City or Te	own. State. Zir	Code)
d2s thar 7 Is trau												
Tan Heal		Sally H. Gell/w 20a. Method of Disposition	viie	20h Bli		Lockdal		Dat			tion - City or To	
ges If of Or o		1 Burial 2 Cremation	3 ☐ Removal from State			sition (Name of natory or other place					,	m, olalo
men men tant:		4 ☐ Donation 5 ☐ Other (Sp.	ecify)	W.		el Cremat			<u> </u>		on, MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm M deal Event instruct by nullfied at once.		21. Signature of Funeral Service L	icensee ///		G	Name and Addre	ss of Facilit	ation	Servi	ce P	.O. Box	× 784
8 2 E 8 9		Derely L	Hallte	MO125	1 B	everly L.	Heck	rotte	, P.A.	Clar	ksville	e, MD 21029
		23a. Part 1. Enter the disease, or o	complications that cause	the death.	. Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
Dhusiaian		shock, or heart failure. List o Immediate Cause (Final	Respira		Failus	50						Onset and Death 3 months
Physician /Medical		disease or condition resulting in death)	_ a			Le						3 HOITCIS
Examiner			Due to (or as			ve Pulmon)i ao a	_			10 ,,,,,,,,,
	er	Sequentially list conditions,	b. Due to (or as			ve Pullion	ату Б	rseas	е	· · · · · · · · · · · · · · · · · · ·		10 years
ed sit	į	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequi	ence oi).							
and -tran	Examin	that initiated events resulting in death) Last	c Due to (or as	0.0000000	2222 25:							
sian urial		rooding in dodiny and	Due to (or as	a consequi	ence or).							
death certificate be executed e attending physician and d for use as the burial-transit	cian/Medical	,	d									
ing p	Mec	IF FEMALE:								T		
th ce rendi	l/ue	23b. Wes decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	ev.			230	d. Date of deliv	•
		in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant a			Other (specify)	,				Month	Day Year
w requires that the is been signed by the should be detached	Physi	9 ☐ Unknown	9 DOUNIOWII									
s tha		Part II. Other significant condition		ut not resul	lting in the ur	nderlying cause giv	en in Part I		23e. Did to	bacco use	contribute to t	he cause of death?
n sig	d b	Diastolic Heart	: Failure		_				1 □ Y	es 2 🗆 I	No 3 ☐ Pro	bably 4□ Unknown
w rec	Completed by	Coronary Artery	, Disease						24a. Was a	an s	24h. Were auto	opsy findings available
has ge 2	E G	coronary meery	BIBCABC						autop	sy	prior to co death?	mpletion of cause of
icate	ပိ	Renal Insuffici	ency							2 X No	1 □ Yes	2 □No
Physician: The law r this certificate has b ral director, page 2 sl	Be	25. Was case referred to medical examiner?	Hagnital			104			Check only or			
hysi this c	ဥ	1 Yes 2 No	Hospital: 1 Inpatie			IL 3 LI DOA					Other (Speci	fy)
ng F	ü	27. Manner of Death 1 ANatural 5 □ Pending	28a. Date of Inju (Month, Da	ıry ıy, Yea <i>r</i>)	28b. Time of Injury	f 28c. Inju Wor	ry at 'k?	28	d. Describe h	ow injury o	occurred	
endi eath. or: /	ati	2 ☐ Accident investiga	ation			M 1 □	Yes 2□	No				
r Att er de rect	ţį	3 Suicide 6 Could no 4 Homicide determin	ned 28e. Place of In	ury - At hor	me, farm, str	eet, factory, office		28	f. Location (S City or Tow		Number or Run	al Route Number,
tal o s aff al Di ed ir	Certification: To											
pspil hour iner			g Physician: To the best									
n 24 n 24 ne Fi	Medical	one)	Examiner: On the basis of and manner st		ion and/or in	vestigation, in my	оріпіоп, аег	ath occurred	at the time,	date and p	nace, and due i	o trie cause(s)
To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	ž	29b. Signature and title of certifier	0.			29c. Licens	e number			29d. Date :	signed (Month,	Day, Year)
		1 Rada	V11-	A-	M.	D2732	2			April	27, 20	009
		30. Name and address of person w	who completed cause of	heath (Itam	23a) (3700	Print)				_		
1/10		Reed M. Shnider				Philip Dr	# 22	5 012	ON MID	2002	2	
01-			32. Registr			TITTLY DE	• #44	OILL	ey, MD	2003	02	<u> </u>
Sta Registr		31. Date filed (Month, Day, Year)	2009 Line	ر به		arkel						

29a. Certifier (Check only one)

Director

Funeral

Be Completed by

ပ

Physician

/Medical

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Invariant interesting the Marylan Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middel Exam in croust be notified at once.

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed

For State Registrar				C	ertific	cate of	Death		Re	g. Noo	nna	15078
. Decedent's Nam	e (First, Middle,	Last)						2	2. Date of Death Month	Day	Year	3. Time of Death
Anna Be	lle Gibb	S							April	20,	2009	10:30A M
		give street and numb	er)		4b. 0	City, Town,	or Location of De	eath			inty of Deat	
7100 E. Social Security N	Spring		Age (In yrs. I	act hirth	au) If II	nder 1 Year	Landov		B. Date of Birth	Prin		orge's thplace (State or Foreig
49-86-5	781	1 M 2 M F	Age (in yrs. i	ast birthda Yrs	Mon			lin.	(Month, Day,		Co	th Carolina
a. State	10b. County		10c. City	, Town or			-					10d. Inside City Limits
MD e. Street and Nu		George's		Lar	ndove	. Zip Code			10	g. Citizen	of What Co	puntry?
		na Ct					0705					•
/ 100 Marital Status	E. Spri	12. Was Decede		S. 1	 3. Was D	ecedent of	10785 Hispanic Origin?	(Speci	ify Yes or No-	14.		erican Indian,
	ed 2/1 Marrie	Armed Force	es?		If Yes,	specify Cul	ban, Mexican, Pu	erto Ri	ican, etc.)		Black, White	
3 Widowed		If Yes, Give Year or Date			1 ∐ Ye	s 2 No	Specify:			Spe	ecify: B	lack
/Sno	15. Decedent's	Education grade completed)		16a. De	ecedent's	Usual Occu	pation during most of t	vorkina	, 1	6b. Kind o	of Business/	
Elementary/Seco		College (1-4	or 5+)	lif	e. DO NO	OT use retir	ed)	· orking	'			
		2yrs		Sv	vitch	Boar	d Opera					vate
	(First, Middle, La	_							First, Middle, M			
David	Cor			Ι.			Maybel			gland		
	ame/Relationship						et and Number or		_			Zip Code)
	Gibbs/ F	iusband	ant D	<u>.</u>			ng St.		andover			Town State
a. Method of Dis Marial 2		☐ Removal from St	1 0	lace of Dis emetery, o	sposition crematory	(Name of or other pla	1	Dat		oc. Locati	on - Oity or	Town, State
4 Donation	5 ☐ Other (Spe	ecify)		surre		n Cen		/25/			on, M	
. Signature	n val Service Lie	censee					ress of Facility over Rd		. Jenki: Landove:			
		omplications that cau		. Do not	enter the	mode of dy	ring, such as can	diac or	respiratory arre	st,		Approximate Interval Between
mediate Cause sease or condition	(Final	*	lignan	t Car	cino	id Tu	mor					Onset and Death
sulting in death)	4	a	as a consequ				-					
	- 1/4/	_h Ma	lignan	t Nec	plas	m, 1i	.ver					
equentially list co any, leading to in use. Enter Unde	naitions, imediate	Due to (or	as a consequ	ence of):								
ause. Enter Unde ause (Disease or at initiated events		cMa	lignan	t nec	plas	m, bo	ne					
sulting in death)	Last	Due to (or	as a consequ	ence of):								
		Ld										
FEMALE: b. Was deceden in the past 12 1 Yes 2	months? No		th 2 ☐ Feta nt at time of d	death		pic pregnar er (specify)	ncy			23d	. Date of de Month	olivery Day Year
		s contributing to dea	th but not resu	Iting in th	e underly	ing cause g	iven in Part I.		23e. Did tob	acco use	contribute to	o the cause of death?
,		Ü		-	Í				1 🗌 Ye	s 201	lo 3□P	robably 4 Unknow
								_			4b. 18/	utanou finalis 1-1-1
									24a. Was an autopsy perform	/	prior to death?	utopsy findings availabl completion of cause of s 2 No
Was case referexaminer?	red to medical	Hee Wall						Death ((Check only one)		
1□ Yes 2			patient 2 🗆			J DOA	ther: 4 🗌 Nursir					ecify)
. Manner of Deat		28a. Date of	Injury Day, Year)	28b. Tim Inju		28c. Inj	ury at ork?	28	Bd. Describe ho	w injury od	curred	
1 XLNatural 2 ☐ Accident	5 ☐ Pending investiga 6 ☐ Could no	tion	24), 1041/		М		□Yes 2□No					

attending physician and for use as the burial-trar certificate has been signed by the irector, page 2 should be detached this within 24 hours after death.

To the Funeral Director:

Completely filled in by the fu

Medical Certification: To Be Completed by Physician/Medical Examiner

53 State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H (066665

			For State	State	of Ma	rylan				lealth : Death		lental Hy		009	15079
_			Registrar 1. Decedent's Name (First, Middle,	. Last)				imout	0 0, 1			2. Date of Dea	947	.000	3. Time of Death
	sicia		Ray W. Gullett	,,								Month 4 /	23/2	2009 Year	3:39 a ^M
	edica mine		4a. Facility Name (If not institution,	give street and n	umber)			4b. City,	Town, or	Location	of Death			County of Death	1
,			Washington Adver	tist Hos	spita	1		Tako	ma P	ark			Mo	ntgomer	:y
Fune	ral			6. Sex 1 🐼 M 2 🗆 F			ast birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, <i>Year</i>)	9. Birth Cou	nplace (State or Foreign untry)
Direc	tor		233-12-3794	IDAN ZLIF		92	Yrs.					10/16/	1916	Mar	ytown, WV
and w		ł	Usual Residence of Decedent 10a. State 10b. County			10c. City	y, Town or Lo	cation			_		-		10d. Inside City Limits
Maryl -fsho		ē	MD Prince	George's	,	Hvat	tsvil	٩							1⊠Yes 2□No
r 28a		Director	10e. Street and Number	000000)		10f. Zip	Code				10g. Citiz	zen of What Cou	untry?
h with		ョ	6011 43rd Street							20781	L			U.S.	Α.
ems		Funeral	11. Marital Status	12. Was De Armed F		ver in U.	S. 13. \	Vas Dece f Yes, spe	dent of H	ispanic Or in, Mexica	rigin? (Spe	ecify Yes or No Rican, etc.)	.	14. Race - Amei Black, White	
s after		by Fi	1 Never Married 2 Marrie	If Yes, C		0		I□Yes		Specify.				Specify:	White
hours aff			3 ☑ Widowed 4 ☐ Divorced 15. Decedent'	Year or	Dates:		16a. Dece	lent's Usu	al Occup	ation			16b. Kir	nd of Business/I	
in 72 n"na		Completed	(Specify only highes	t grade completed			/Give	kind of wo	rk done o	durina mos	st of worki	ng			,
Z I Z I with giene or tha		E	Elementary/Secondary (0-12)	College	(1-4or 5+	-)	Coalm:	iner					Coa1	l Indust	ry
land		Be	17. Father's Name (First, Middle, L	.ast)						18. Moth	er's Name	(First, Middle,	Maiden .	Surname)	
Vial Ment Ment arked	2	၉	Daniel Buford Gu	ıllett							tha B				
2 sho			19a. Informant's Name/Relationsh				1	0	•					r Town, State, 2	Zip Code)
e, n l and lealth lealth			Geraldine Griffi 20a. Method of Disposition	n / daug	ghter							tsville		cation - City or	Town State
Designmore, IMERYIGHTO ZIZIO-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item ZI is marked other than "natural", or items 23 or 28a-f show any Initian or other trainments.	5		1 ☐ Burial 2 🖾 Cremation		n State		lace of Dispo emetery, cren				4/25			,	, Virginia
DELLITION Dermit. Pages Department of mportant: If it	1		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Fundal Service L			Met	ropoli			ss of Facili		709			more Avenue
Depired Depire	Book		21. Signature of Puncial Service	1/1/2	100	0					,	e. P.A.		-	Le, MD 20781
			23a. Part 1. Enter the disease, or	complications that	caused	the death									Approximate Interval Between
Physici	an		shock, or heart failure. List of	only one cause on	each line	e. V271	utest	inc (H	teme	rah	age		1	Onset and Death
/Medic	cal		disease or condition resulting in death)				uence of):					10.			
Examir	•	.	Sequentially list conditions,	b											
ed ed		ine	if any, leading to immediate	Duet	Uras a	consequ	uerios of):								
xecut and		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a	consequ	uence of):								· · · · · · · · · · · · · · · · · · ·
icate be executed physician and the hurial-transit		dical					·								
				u							-				
iries that the death certifications by the attending		Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	utcome o			Ectopic	regnanc	v			1	23d. Date of del	
deal deal		Sici	in the past 12 months? 1 ☐Yes 2 ☐ No		gnant at			Other (s		,				Month	Day Year
at the			9 Unknown	1			المام الم			aa in Dank		220 Did t	obacco u	ico contribute to	the cause of death?
res the		<u>۾</u>	Part II. Other significant conditio	ris contributing to	uean bu	i noi resi	alting in the ti	idenying (ause giv	eninran				□ No 3 □ Pr	V
v requires to been signed should be a		Completed													
le law		ğ										24a. Was autop perfo		prior to death?	itopsy findings available completion of cause of
n: The		- 1	25. Was case referred to medical							00 PI		1 □Yes	2 100	1 □Yes	2 □ No
din Of VII all hecords, P. C. BOX of ding Physician: The law requires that the death certifully. After this certificate has been signed by the attending funeral director nane 2 should be detached for use as		o Be	examiner?	Hospital:] Inpatier	nt 2 N	£ R/Outpatier	at 3□D	Oth	er.		n <i>(Check only o</i>		6 □Other (Spe	cifu)
9 Phy er this		- 1	27. Manner of Death	28a. Dat	e of Injur	y (28b. Time of Injury		28c. Injur Wor			28d. Describe			ony,
Attending at death.		atio	1 Matural 5 ☐ Pending 2 ☐ Accident investig	ation	нин, рау	, rear)	injury	М		Yes 2]No				
Y Atte		ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Pla bui	ce of Inju	ry - At ho	ome, farm, str	eet, factor	y, office			28f. Location (City or To			ural Route Number,
ralo litalo La		Ç													
\ DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A		Medical		g Physiclan: To t Examiner: On the and ma		examina									
To the To the Vithin		ğ M	29b. Signature and title of certifier	7	1	1	1 4	c 29		e number	_	· · · · · · · · · · · · · · · · · · ·	29d. Da	te signed (Mont	th, Day, Year)
> - 0			> y K	Tyli	for	01 /	E / C	1/	52	132	6		4	- 23 -	-09
5			30. Name and address of person v	who completed ca	use of de	eath (Iten	n 23a) (Type,	Print)							
			James K. Lightf	oot, Jr.	, 20	010	Centur	y B1	vd.,	Germ	anto	wn, MD	2087	4	
	Stat	e	31. Date filed (Month, Day, Year)	32.	Registra	r's Sina	ture	2.3							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene/) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY ALMA DEAN GRISSOM 2009 12:55PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7150 BENSVILLE ROAD WHITE PLAINS CHARLES 8. Date of Birth (Month, Day, Year)

JUNE 26,1935 KFNTUCKY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2√2 XE 403-48-7331 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 1 □Yes 2 No VA KING GEORGE **JERSEY** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12104 BROOKS DRIVE 22481 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: WHITE Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK DALTON NONA WALDRON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DELANO GRISSOM/SPOUSE 12104 BROOKS DRIVE JERSEY, VA 22481 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State TRINITY MEM.GRDNS. 9,2009 WALDORF, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licenses Jas M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final N disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24a Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

<u>م</u>

Completed

Be

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Funeral

Director

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience must be recitified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event

Saltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

Examir Physician/Medical

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Completed

Be

Certification: To

Medical

that the death certificate be executed burial-transi attending physician for use as the buria the detached signed by t page 2 should certificate Hospital or Attending Physician; this funeral After 24 hours after death. Funeral Director; A the filled in by

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1 □ Yes 2 ☑ No

RESIDENCE

25. Was case referred to medical examiner? 1 ☐ Yes 2 🗙 No 27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) DAUGHTER \square S 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier MD

D0026064

29d. Date signed (Month, Day, Year) 05-05-200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIDYASAGAR ANMANGANDLA, MD.

10583. THEODORE GREEN BLVD WHITE PLAINS, MD- 20695

State Registrar 32. Registrar's Signature

31. Date filed (Month, Day, Year) Darks

within 2 To the I

DIL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decement's Name (First, Middle, Last) **Physician** 20cm 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Jown, or Location of Death Examiner ned A 3 inde If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Jan 3 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**√** M 2□ F 1954 Maryland 217-62-9264 55 Jan Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be retilled at ¶Yes 2 □ No Maryland Anne Arundel Annapolis, Director with the 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21401 USA 2026 Forest Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or ite ary or other traumatic event, the Medical Examina. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2\tag{\tag{\tag{\tag{No}}}} No Specify Specify: Black ģ 3 Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor 12thMcDonalds 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laurence Taylor Mary Eades ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2026 Forest Dr. Annapolis, Md. 21401 Jason L. Hill(Son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. 4-24-09 Memorial Park Annapolis, Md. Winname Reverse of Eacil Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. Beese MOOE83 a-vy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Physician Trteriosc /Medical Due to (or as a consequence of): Examiner oerte if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last N5 Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami betes A burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ned by the a 9 Unknown signed I I be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 100 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation nours after death.

neral Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN No

State Registrar

DHMH 17 Rev 1/2001

HESIETE AFRET Z

31. Date filed (Month, Day, Year)

			1 _ State			of Health a of Death	and Mental H	ygiene,	2009	15082
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of I			3. Time of Death
	Physici		Nina Audrey Parsons Henr	:у			Month April	22, Day	009 Year	9:50A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, T	own, or Location o			County of Death	
فممس	=xa		Anne Arundel Medical Center		Annap	olis		A	nne Aru	ndel
	Funeral		4 T W	(In yrs. last birth		Year If Under 2 Days Hours	24 Hrs. 8. Date of I Min. (Month,	3irth Dav. Year)	9. Birth	nplace (State or Foreign untry)
	Director		228-14-4072	Υ	rs.	Days	7/4/	1920	Vir	ginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits
	/aryla	ō	Maryland Anne Arundel							1 □ Yes 2 □ No
	28a-	Director	10e. Street and Number	Edgewa	10f. Zip (Code		10g Citiz	zen of What Cou	
	with 3a or					.037			ISA	
	ms 2:	Funeral	3669 1st Ave. 11. Marital Status 12. Was Decedent Ev	er in U.S.			gin? (Specify Yes or i	1	14. Race - Amer	rican Indian.
9	or iter		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No.)			gin? (Specify Yes or i , Puerto Rican, etc.)		Black, White,	, etc.
8	ral", c	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □ Yes 2,	No Specify:			Specify: Wh:	ite
5-0	be filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f show edent, I're 'ledical Erric her half be nothed	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. [Decedent's Usual	Occupation done during most	of working	16b. Kir	nd of Business/li	ndustry
2	ithin ne.	du	Elementary/Secondary (0-12) College (1-4or 5+))	life. DO NOT use	retired)				
2	led w Hygie her t		2	Hot	sewife/	Homemaker	-		Home	
anc	l be fi ntal H ed ot ed ot	Be	17. Father's Name (First, Middle, Last)				r's Nam <i>e (First, Midd</i>			
Ë	should be f and Mental s marked o tumatic eve	P	William Wingfield Parsons 19a. Informant's Name/Relationship (Type. Print)	405	(4.75 A.d.)		a Florence			
Z	and 2 s ealth an n 27 is i		Duane Googe/Daughter	1	-		er or Rural Route Nur. Water,MD.		Town, State, Z.	ip Code)
ā,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene from the state of 28a-f show then traumatic event, I'te hedeal Even her wat by within a other traumatic event, I'te hedeal Even her wat by within a state of the		20a. Method of Disposition		Disposition (Name crematory or oth		Date	_	cation - City or T	Town, State
Baltimore, Maryland 21215-0036	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		-		4/27/2009		dsonvil	
≣	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.	Ξï	21. Signatur Funeral Service Licensee	Lakelio			George P.			
m	an per		Act Kala				sland Rd.			
			23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	ne death. Do no					,,,,	Approximate Interval Between
	Physician	(P	Immediate Cause (Final disease or condition	1 . 11	1- + 1	- ileur			1	Onset and Death
	/Medical		resulting in death)	consequence of	an 1	ailene				avye
	Examiner		Sequentially list conditions b Mys-Co	udial	Infa	ection				dans
	p #	iner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					0
	and trans	Examiner	that initiated events	my op	Huz					years
90	be e) ician burial		Due to (or as a	consequence of		,				
68760,	tificate be executed g physician and as the burial-transit	edical	dabrille	2 340	wous				+	years
	= 0, e	<u> </u>	IF FEMALE: 23c. If yes, outcome of	foregnancy					Od Data of dati	
Box	death a atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at t	Fetal death	3 Ectopic pre				23d. Date of deli Month	Day Year
0	I he law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	9 Unknown							
ري ت	s thai ined l	by P	Part II. Other significant conditions contributing to death but	not resulting in t	he underlying car	use given in Part I.	23e. Di	d tobacco us	se contribute to	the cause of death?
Records,	v requires been sign should be	edk	Urinary Tract Infee	tion			1 [Yes 2]No 3∏ Pro	obably 4 🗗 Unknown
ပ္ထ	e law requir has been s je 2 should	Completed	hypertension				24a. W		24b. Were au	topsy findings available
		mo;	Obico Filipportion				pe	topsy rformed? s 2 ☐tNo	prior to c death? 1 □ Yes	completion of cause of
Vital ∴	sıcıan: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?			26. Place	of Death (Check onl		10163	2010
	Physician: r this certific ral director, I	2	Hospital:	t 2 ER/Outp	atient 3 DOA	Other: 4 □ Nu	rsing Home 5 🗆 Re	esidence 6	i □Other (Spec	cify)
ב ב	ding Physi h. After this c funeral dire	ii o	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day,	Year) 28b. Tir	ury	c. Injury at Work?	28d. Describ	e how injury	occurred	
S	ttend death death ttor: , the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be one Place of Injury		М	1 ☐ Yes 2 ☐ N				
Division of	or At after d Direct In by	Certification:	4 Homicide determined 28e. Place of Injury building, etc.	y - At nome, tarn (Specify)	n, street, tactory,	office	28f. Location City or 1	(Street and own, State)	I Number or Ru	ral Route Number,
	e hospital or 24 hours afte Funeral Dir letely filled in		29a. Certifier 1 Certifying Physician: To the best of	my knowledge,	death occurred a	t the time, date an	d place, and due to t	he cause(s)	and manner as	stated.
:	lo the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical Examiner: On the basis of e and manner state	examination and/	or investigation,	n my opinion, dea	th occurred at the tim	e, date and	place, and due	to the cause(s)
1	vithin To the compl	Ž	29b. Signature and title of certifier		29c.	License number		29d. Date	e signed (Month	n, Day, Year)
			fring Lavis, mo			53111	,	41	122/0	9
1	11 OI		30. Name and address of person who completed cause of dea	ath (Item 23a) (T	ype, Print)	A .		· · · ·		
1	RX		Hung DAvi's 2001 Media 31. Date filed Month, Day, Year) 32. Registrar	al PArl	Muray,	Amapoli	s, Md	21401	,	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar'	o Gigilature	1	,				
			THE A LOUD CENTER	V A.	JERKY!					

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4a. Facility Name (If not institution, give street and number) Examiner BURNI GLEN ANNE MEDICAL CENTER BALTIMORE WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Year) Months Days Hours Min. 1 M 2 XF 84 219-10-3003 20,1924 Director Sept. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County show r than "natural", or items 23a or 28a-f show Severna Park MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 164 Boone Trail Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🔀 No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, trainsones. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Nellie Marie Adams William P. Warner ဥ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severna Park, MD 21146 Joseph M. Hunter/ Husband 164 Boone Trail altimore, April 24. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remover from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2009 Crownsville, MD 21. Sonature of Fineral Service Licenses Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. P. 1. E for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, in heart failure. List only one cause on each line.

Assignation Preumonia ne. Aspiration Pneumonia Immediate Cause (Final Physician disease of condition resultion in death) /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit be executed UBE SITE INFECTION GASTROSTOM) Due to (or as a consequence of) Box 68760, Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🙀 No 5 Other (specify) signed by the a P.O. I 9 Unknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBSTRUCTIVE

28a. Date of Injury (Month, Day, Year)

Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

determined

1. Decedent's Name (First, Middle, Last)

Betty Jean Hunter

Physician

/Medical

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 XNo 1 ☐ Yes 2 XNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

Month

23e. Did tobacco use contribute to the cause of death?

29a, Certifier

25. Was case referred to medical examiner?

1∐Yes 2**⊠**No

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 D0061832 17 anne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4b. City, Town, or Location of Death

2. Date of Death

Month

3. Time of Death

10:28 A M

ARUNDEL

10d. Inside City Limits

Approximate Interval Between Onset and Death

MONTH

Month

Year

1 ☐ Yes 2X No

Birthplace (State or Foreign Country)

Maryland

14 Race - American Indian

Black, White, etc.

Specity: White

Year

2009

4c. County of Death

USA

Home

30
For Ameno#23a, c per PHY
State of Maryland / Department of Health and Mental Hygiene
State
Registrar4/23/09 AACO HEALTH DEPT. ONH
Certificate of Death
Reg. No.

30. Name and address of person who compreted cause of death (Item 23a) (Type, Print) 301 Hospital Drive, Glen Burnie, MD 301 Hopspital Drive Glen Burnie, MD 21061

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Records,

of Vital Physician:

Division

Attending After

Hospital 24 hours

spital or Attendii ours after death. neral Director: A filled in by the fu death.

To the 1 within 2 To the

à

Completed

Be

Certification: To

Medical

been si

has page 2

certificate

director,

funeral

3. Time of Death

1 ☐ Yes ⊀ No

Were autopsy findings available prior to completion of cause of

2 No

1058

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

death.

Examiner Physician/Medical Completed by Be Certification: To Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy 2 🛚 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Funeral Director: After completely filled in by the funer within 24 hours a

State

Registrar

Heather 31. Date filed (Month, Day, Year)

22 S. Greene St, Baltimore, MD 21201 MD Sheets 82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Michael David Hopkins April 23, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 215-52-5242 December 5, 55 1953 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Silver Spring Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20905 15412 Aylesbury Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2XX Married 5 ltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u></u> 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter 12 and Mental Hygir 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Betty Frances Doran James Robert Hopkins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15412 Aylesbury Street, Silver Spring, MD 20905 Health a Carole S. Hopkins / Wife permit. Pages 1 and Speathent of Health Important: If Item 27 any injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Alexandria, VA April 24, 2009 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. West, 21. Signature of Funeral Service Licensee Allesa Arevalo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Severe Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) P.0 9 Unknown s been signed b 23e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 24a certificate Division of Vital 1 🗆 Be 25. Was case referred to medical 26. Place of Death (Check

neral Service Licer	Arevalo	Franci	Address of Facility s J. Collins F iversity Blvd.	un∈ W∈	eral Home I est, Silver	nc. Spring,	MD 20901
rt failure. List only Final	plications that caused the death. Do not cause on each line.		of dying, such as cardiac	or re	espiratory arrest,		Approximate Interval Between Onset and Death
•	a. Respiratory Fail						
•	Due to (or as a consequence of	,					
ditions,	b. Severe Pneumonia						
nediate lying njury	Due to (or as a consequence or):					
ast	Due to (or as a consequence or	r):					
pregnant months?]No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pre				23d. Date of o	delivery Day Year
cant conditions	ontributing to death but not resulting in	the underlying cau	ise given in Part I.				to the cause of death?
					1 ☐ Yes	2 X_X .No 3∐	Probably 4 Unknown
					24a. Was an autopsy performed? 1 □ Yes 2 🟋	prior t death	
ed to medical			26. Place of Dea	th (C			oo Laganto
No	Hospital: 1 ↑ Inpatient 2 □ ER/Out	nationt 3 🗆 DOA	Other:		5 Residence	6 DOther /C	nacify)
5 ☐ Pending investigation	28a. Date of Injury 28b. Ti		c. Injury at Work? 1 □ Yes 2 □ No		d. Describe how inj		pecity)
6 Could not be determined	28e. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, o	office	28f	Location (Street City or Town, Sta	and Number or ate)	Rural Route Number,
1XX Certifying Ph 2☐ Medical Exar	nysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred a l/or investigation, i	t the time, date and place n my opinion, death occu	e, an	d due to the cause at the time, date a	(s) and manner and place, and c	r as stated. due to the cause(s)
itterof certifier	Tay mo	'	License number 063579			Date signed (Mo	onth, Day, Year) 2009
1 '1	completed cause of death (Item 23a) (500 Forest Glen Rd., S	* * * *	ng, MD 20910				
h, Day, Year) 27 200	9 P. Registrar's Signature	arked					
		ORIGINAL					

3. Time of Death

1:15a

Birthplace (State or Foreign
 Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Philippines

Year

USA

Black, White, etc.

Commercial

White

within 24 hours a

To the

ieral Director: A

Certification: To

Medical

1 Yes 2 No

30. Name and address of person who completed cause

27. Manner of Death

1 Natural

2 Accident

4 Homicide

29b. Signature and title of certified

Maria Tayag 31. Date filed (Month, Day,

3 ☐ Suicide

29a. Certifier

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Hulda Emmaline Holter 4 20 2009 7:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Rehabilitation Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 214-34-1196 2/28/1915 94 Director VA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Frederick Funeral Director Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4805 Old Middletown Rd. 21755 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) cafeteria manager public schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental I Lemuel Frost Caroline Elizabeth mabe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Dade (Daughter) 4805 Old Middletown Rd., Jefferson, MD21755 20b. Place of Disposition (Name of Renewal Stand to Notice Wile (Name of Church 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation B □ Removal from State injury or of Brethren Cemetery 4/24/09 4 □ Domation 5 □ Other (Specify) 21. Signature : Funeral Service L Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Approximate Interval Between Oaset and Death 231. Part1. Enter the dis shock, o heart failu Immedial cause (Final or comflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one lause in each line. ter the disease, or complicated the disease, or complicated the disease, or complicated the disease the disease of the disease Physician 200 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to for as a consequence off Examiner it any, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): 6. Bdx 68760. Physician/Medical use as ed by the attending a IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown signed by t Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No performe 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 1 Tes 1 🔲 Inpatient ၉ 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation spital or Attendl nours after death. neral Director: A filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral D 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 18

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Registrar

RIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 2009 VERNON ANTHONY HOWE 5:37A M 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death CHARLES 10550 BOX ELDER ROAD LA PLATA 8. Date of Birth (Month, Day, Year) MAR . 13 , 1959 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours Min. 1 X M 2 □ F 218-98-2129 50 MD. Usual Residence of Decedent 10d Inside City Limits 10c City Town or Location 10a State 10b. County 1 Yes 2 No MD CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10550 BOX ELDER ROAD 20646 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2□No 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS WILLIAM HOWE SR. ANNA CECELIA WATHEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) THOMAS W. HOWE JR./BROTHER 6804 HALLOWING PT.LN., BARSTOW, MD 20610 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ST.MARY'S CEMETERY 8,2009 BRYANTOWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service License 5635 WASHINGTON AVE., mrs. M00641 LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 505 IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectop c pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a Was an autopsy 1 ☐ Yes 2 K No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 3

Baltimore, Maryland 21215-0036

Examiner must be notified at

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Department of Important; If it any Injury or o once.

Director

Funeral

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The law requires that the death certificate be executed

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Vital Physician:

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Division Hospital or Attending

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Examiner Physician/Medical δ Completed Be Certification: To funeral n 24 hours after death.

le Funeral Director: Af

25. Was case referred to medica examiner? 1 Yes 2 No 27. Manper of Death 1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a, Certifier

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Aand manner states 29d. Date signed (Month, Day) 29b. Signature and title of certifier

addres of perso who completed cause of death (Item 23a) Type Print

31. Date filed (Month, Day,

Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Day Month Year 2009 April Jackson 4b. City, Town, or Location of Death 4c. County of Death Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) Min. 1 ☐ M 2 🔀 F Months Days Hours 84

1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:15 Marie /Medical 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Larkin Chase Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 577-34-5201 Jan 18, 1925 Georgia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show th and Mental Hygiene.
?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, it all wolch. ty Yes 2 □ No Director District of Columbia Washington the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20019 United States 200 - 56th Street, NE Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 2 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education within 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Housewife years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any linjury or other traumatic evonce. Alice Osby မှ Bishop Booker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9875 Good Luck Road #T1 Lanham, MD 20706 Marilyn Wanzer - Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery April 29, 2009 Brentwood, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. nture of Euron A Service Lice 4001 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Carcinoma of the Colon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and Due to (or as a consequence of): physician s the burial Box 68760, certificate be Physician/Medical as attending IF FEMALE: nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed this certificate 1 ☐Yes 2 ☑ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. I Director: After d in by the funera Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit) April 24, 2009 D43351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ikechi F. Okwara, M.D. 6201 Greenbelt Road #U15 College Park, MD 20740 Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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	on 1	State of Maryland	d / Department of Health and Mental Certificate of Death	2000 100
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Continuate of Dodain	Reg. No. 2. Date of Death 3. Time of Death
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		4a. Facility Name (if not institution, give street and number 6998 Powellville Rd	er) 4b. City, Town, or Location of D Willards	Death 4c. County of Death Wicomico
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uneral irector		220–26–4019 TX M 2 F	82 Yrs. Months Days Hours	OCT. 26, 1926 Foreign Country) MD
,		Usual Residence of Decedent	10c. City, Town or Location	10d. Inside City Limi
w an	4	10a. State 10b. County MD WICOMICO	WILLARDS	1 Yes 2 X N
Tages I and a should be throwning to brown after death with the brady and meet of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	희	10e. Street and Number	10f. Zip Code	10g, Citizen of What Country?
r 28a	Director			USA
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than than	힐	10	TRUCK DRIVER	TRANSPORTATION
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ntal H rked	8	GEORGE JACKSON	EMMA	
nound nd Me is ma	유	19a. Informant's Name/Relationship (Type, Print)		er or Rural Route Number, City or Town, State, Zip Code)
and 2 Stealth ar		BEATRICE M. JACKSON/WIF	E 6988 POWELLVILLE RO	OAD, WILLARDS, MD 21874 Date 120c. Location - City or Town, State
S I an of Hea if ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from	State crematory or other place)	,
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permit. Pages I Department of F Important: If i injury or other		21. Ign - June of Fune al Service Jonasea	22. Name and Address of Facility	HOME CELEVATILE DE 10075
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		or condition resulting in death) Due to (or as a co	insequence of):	
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certificate has been ector, page 2 should	Ç		OC Plant of Doots (1 Yes 2 No 1 Yes 2 No
ysician: his certifi director,	Be	25. Was case referred to medical examiner? Hospital: 4 lor	26.Place of Death (Contained 2 ER/Outpatient 3 DOA Other	Nursing Home 5 Residence 6 Other: Scene
Physic er this eral dir	7	1 Ves 2 No Inc. 27. Manner of Death 28a. Date of	patient 2 Ervedthamin e Bert	
tending Phy eath or: After the the funeral	ertification:	1 Natural 5 Pending Apr 21, 20		Subject fell at home
	ica	2 Accident Investigation 3 Suicide 6 Could not be	of Injury - At home, farm, street, factory, office building, etc	28f. Location (Street and Number or Rural Route Number, C
r Att		3 Suicide 6 Could not be		or Town, State)
of the Hospital or Attending Physician: The law requires that the death certificate be dithin 24 hours after death from this certificate has been signed by the attending physici or the Funeral Director: After this certificate has been signed by the attending physici ompletely filled in by the funeral director, page 2 should be detached for use as the buri	Certif	4 Homicide determined (Specify)	home	6998 Powellville Rd, Willards, MD

Theodore M. King, Jr., MD. 31. Date filed (Month PR Y2 4 2009 Registrar

Assistant Medical Examiner 32. Registrar's Signature

30. Name and address of person who completed cause of death (from 23a)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

April 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 15258M DUBUD J. 33 2009 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 1 ₹ M 2 🗆 F 77 April 16, 1932 Connecticut 133-22-6766 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 1 Yes 2 No Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21403 U.S.A. 992 Elizabeth Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1956–77 1 Never Married 2 Married 1 Yes 2 No Specily Specily. White 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lieutenant Colonel U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Kristoff, Sr. Alberta Bradis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kristoff/wife 992 Elizabeth Drive Annapolis, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 remation 3 Removal from State 4/25/2009 Baltimore, Maryland Baltimore Crematory 5 Other (Specily) 4 Donation 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 U Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line

2009

600 North Wolfe St, Baltimore, MD, 21287

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Physician

/Medical

Examiner

10a. State

Funeral

Director

ms 23a or 28a-f show must be notified at

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Funeral Director

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Completed

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the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

al Examiner	Immediate Cusie (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	vence of):	No Civ	Busan.	,,,,,	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	death 3 Ectopic			23d. Date of d Month	lelivery Day Year
by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlyin	g cause given in Part I.		tobacco use contribute Yes 2 No 3	1
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Be (25. Was case referred to medical			26. Place of	Death (Check only	one)	
년 B	examiner? 1 2 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆 [OOA Other: 4 🗌 Nursi	ng Home 5 🗆 Res	sidence 6 🗆 Other (Sp	ecily)
	27. Manuer of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 _ Yes 2 _ No		how injury occurred	la .
Sertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify		ory, office	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
Aedical C	29a. Certifier (check only one) Certifying Phy 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina end mapner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and on, in my opinion, death	place, and due to the occurred at the time	e cause(s) and manner e, date and place, and o	as stated. due to the cause(s)
Je l	20h Signature and title of certifier		. 2	9c. License number		29d. Date signed (Mo	nth, Day, Year)

DHEN State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 4/21/2009 **Physician** 605pm ^M James Joseph Kearns Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/10/1935 9. Birthplace (State or Foreign 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 1 M 2 □ F 174-28-8897 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pearment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic event. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 1 □Yes XIX No Funeral Director MD Anne Arundel Gambrills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 895 Snow Ridge Circle 21054 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 28 Married 1 ☐ Yes 2 ☑ No Specify White If Yes, Give Year or Dates Specify: Completed by 3 | Widowed 4 | Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Special Service manager Phone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James P. Kearns Cornilia Pacurar မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 895 Snow Ridge Circle Gambrills, MD 21054 Donna Kearns Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Eremation 3 ☐ Removal from State 4/27/2009 Glen Burnie, MD Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fulleral Service Profisee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MAHOMA **Physician** 7/20 disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 💟 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an VeV certificate has b irector, page 2 sh autopsy 1 Yes 2 Delo To the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this c Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier Amagalis Med 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eterson 206011 MD 32. Registrar's Signature Date filed (Month, Day, Year) APR 23 Registrar

			For State Registrar			of Mary	land / [•	rtmen tificate				/lental Hy	Reg. No		ng	line (192
	Physicia		1. Decedent's Name		, Last)								2. Date of De Month	Da Da 23		Year 009	3. Time of	Death — M
	/Medic Examin		Betty Kat 4a. Facility Name (II		, give street and n	umber)			4b. City,	Town, or	Location	of Death	April		. County		5:45	р
1			Suburban			T =			Beth		If Under	OA Hre	D D-4/ Di			omer	y place (State o	
- 1	Funeral Director		5. Social Security No. 215-52-71		6. Sex 1 □ M 2]2 F	7. Age (In	n yrs. last bir	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D			Pol:	ntry)	or Foreign
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amp originary or other traumatic event, It. If which Examiner must be notified at once.		21. Signat	neral Service I	icensee	M012	.55						ard Sag , Rocky	-				lon Inc.
	Physician /Medical		23a. Part1. Enter the shock, or head immediate Cause (disease or condition resulting in death)	rt failure. List o Final	a. Seps	each line.			er the mod	e of dyin	g, such as	cardiac	or respiratory a	arrest,			Approximat Interval Bet Onset and I	tween Death
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3760	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or that initiated events resulting in death) L	i	U	ration o (or as a co			a 							2	l Days	
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of \	Physic this c		1 Yes 2 ₹			Inpatient		utpatien			4 L N	ursing H	ome 5 Res				fy)	
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Katz, Be Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page	Certification: To	3 Suicide 4 Homicide	6	ot be 28e. Plac	ce of Injury - ding, etc. (S	At home, fa Specify)	arm, stre	eet, factory	office			28f. Location City or To			er or Rur	al Route Nun	nber,
Š	ne Hospitu n 24 hours ne Funera pletely fille	Medical (29a. Certifler (Check only one)	1 Certifyin 2 Medical I	g Physician: To ti Examiner: On the and ma	ne best of m basis of exa nner stated.	amination a	e, death	occurred estigation	at the tir , in my o	ne, date a pinion, de	nd place ath occu	, and due to the	e cause(, date an	s) and mand place,	anner as a	stated. o the cause(s	s)
	To the vithin comp	Ž	29b. Signature and		11	A	7	mo			e number						Day, Year)	
	10		30. Name and addre	ess of berson	who completed ca	use of death	Ve !			.005	1268			Apr	11 23	3 200	17	
			Nancy P.	Lawles					,	Ве	thesd	a, M	D 20814	4				
	Sta Registr		31. Date filed (Mont	th; Day, Year)		Registrar's			M.S.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 24, Day 2009 Physician 440 AM M Kahn Benjamin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Renaissance Gardens at Riderwood Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 0272171515 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours New Jersey 94 Months 153-09-4958 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. In a fine I was the profiled and once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20904 3114 Gracefield Road, WC-411 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married White timore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: <u></u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Paper Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goldie Schulman Harry Kahn P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darnestown, MD 20874 13613 Esworthy Road Gary Kahn-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/27/2008 Adelphi, Maryland Mt. Lebanon 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 1091 Rockville Pike Rockville MD 20052 Direction Bai Donald (Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic Bowel Diesease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or se a consequence of): death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical 35 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö the 1 Tyes 2 No 9 Unknown signed by to be a detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? Yes 2 No page certificate 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 24, 2009 D36716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road Silver Spring, MD 20904 Andrew Kundrat, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

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permit. Pages 1 and 2 should be lied within 72 ho permit. Pages 1 and 2 should be lied within 72 ho popuration of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		21. Signature of Funeral Service	Licensee	Po	2							-		al Ho			
TO = 40	-	23a. Part 1. Enter the disease, of	r complica	ations that o	hazusad	the death				ms Stree				lary1a		21811 Approximate	
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/Medical		disease or condition resulting in death)	Ta.	Due to	(or as a		Jence of):	(6)							+-	- days	~
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ding F h. Atter funera	tion:	27. Manner of Death 1 Natural 5 Pendi	ng igation	28a. Date (Mon	of Injui oth, Day	y , Year)	28b. Time Injury		28c. Injury Work	yat :? Yes 2 ∐No	28d. [Describe I	how injury	occurred			
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certified completely filled in by the funeral director, to	edical			er: On the b	pasis of	examina				ne, date and plac pinion, death occ							
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		State of Maryland / Department		lental Hyg	giene	
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Physic		Shirley Ann Kiblinger		Month April	28 2009	3:00A M
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Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day	v, Year) Co	thplace (State or Foreign ountry)
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Physician: The la	Completed			autops perfor 1 □ Yes	med? phor to death?	completion of cause of ≥ 2 □ No
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To the Hospital or Att. within 24 hours after de To the Funeral Direct. completely filled in by t		29a. Certifier (Check only (Ch	t the time, date and place, n my opinion, death occur	and due to the or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
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Baltimore, Maryland 21215-0036

Box 68760 Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:17РΜ 26 2009 Helen Virginia Kepner April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1044 View St. Washington County Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2X F Months Days Hours 213-18-9342 Director Jan. 21.1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evantical must be notified at angles. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1X Yes 2 □ No Funeral Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1044 View St. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S Airforce Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Keller ဥ Gay Nellie Koogle Keller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1044 View St. Hagerstown, MD 21742 Millard Scott Kepner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4-29-2009 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part 1. Enter the disease, or complicated that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

3H-10

State

Registrar

DHMH 17 Rev 1/2001

Michael

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mack

32. Pegistrar's Signature

11110

041667

Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Month Day Year **Physician** KNOX RUBY MAE APRII 25 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOLY CROSS HOSPICE SILVER SPRING If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Ane (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛱 F 578-50-2599 Yrs. Director AUGUST 1937 NORTH CAROLINA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director PRINCE GEORGE'S LANDOVER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a Completed by Funeral USA 20785 3107 82nd AVENUE . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married BLACK o, Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2 🕅 No Specify 3 ☐Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DOMESTIC 12TH Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I Be LITIE DAVIS LEUTE MCLEAN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City of Town, State Zin Code) 3107 82nd AVENUE LANDOVER, MARYLAND 20785 EULIS KNOX JR/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LANDOVER, MARYLAND 5/2/2009 HARMONY CEMETERY 4 Donation 5 Dother (Specify) 22. Name and Address of Facility JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses J. B. 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** RENAL FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Fuheral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit PNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CVA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔣 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 2009 27 APRIL D62571 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BI BROMELAND MD 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 SARAH J. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

AMENDED BY COURT Place type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 09:40 AM 26 2009 Killian IV George Park 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SALISBU MD HOSPICE ATTHELUKE DASTAL WICOMICO 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Min Months Days Hours 1⊠M 2□ F Director 230-20-5-12-1928 Washington, D.C. 80 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it s Medical Exemples munt to profife dial 1 ☐ Yes 2X No Director MD Wicomico Salisbury 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 30735 Old Fruitland Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21⁄2 No Specify Specify: White ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I be filed within 7 intal Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Its Mesonce. Elementary/Secondary (0-12) College (1-4or 5+) Commercial Publication 12 Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Virginia Williams George P. Killian III ပ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21804 <u>Lucie Killian - Wife</u> 30735 Old Fruitland Road, Salisbury, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva: 4-27-2009 | Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA **Physician** LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly groups that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical Hospital or Attending Physician: The law requires that the death certificate attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) o ed by the a a Unknown has been signed e 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page certificate 2 200 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GASTAL HOSPICA (chu utu State Registrar

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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person with pleted cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person with pleted cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person with pleted cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person with pleted cause of death (Item 23a) (Type, Print)	Divisi	Certifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h building, etc. (Spec	.L nome, farm, str ify)	eet, factory	, office		28f. Location (. City or To	Street an wn, State	nd Number or Ri	ıral Route Number,
30. Name and address of person when pleted cause of death (Item 23a) (Type, Print) William Shairm 1075 Falls Rd #415 (Menille, MD, 21993	ne Hospit n 24 hour ne Funer?		(Check only 2 Medical Exami	ner: On the basis of examin								
30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) William Shaifm 1075 Falls Rd #415 (Menille, MD, 21993	To th within	M	29b. Signature and title of certifier	MD		290	_					h, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	OHICH				1 Fer11	Print)		7.70	menlla			93

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 6:30 P. M Herman R. Loper 2009 April 14, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Heritage Harbour Nursing Home Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 87 281-10-6513 Director Dec. 14, 1921 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 √ Yes 2 No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be result in the Medical Examiner must be resulted. 2700 South Haven Road 21401 U. S. A. Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1941–45 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Laminated Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Loper Edna Ervin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2543 Arbor Court, Davidsonville, Maryland Karen Colburn/Daughter 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Grds. 4/20/2009 4 Donation 5 Dother (Specify) New Carlisle, Ohio 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home - Kyri 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mouia **Physician** aediac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Due to (or as a consequence of): Box 68760 ed by the attending physician detached for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 a 1 ☐ Yes 2 ☐ No 3 ☐ Probably been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar 29a. Certifier

29b. Signature

tya

Medical

Ave #231 Annapolis Ad tya Chopra
31. Date filed (Month, Day, Year) 600 APR 22

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

🖰 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

		Please Type or Prin				_	_			
	-	For State Of IVIS	-	Department of Certificate of		≀ientai Hygier Reg.†	- 0 0 0 0	1510	11	
		Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death	h	
Physicia /Medic	al	Leonard Ludwig Lundholm				April 24	2009	6:40 A	М	
Examin	er	4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. County of Dear	th		
Funeral			e (In yrs. last birt	thday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Charles 9. Bir	rthplace (State or Fore	eign	
Director	}	579-30-3158 1 ^{™ 2□ F}	79	Yrs. Months Days	Tiours Will.	July 10, 1	1929 Nev	v York		
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Lim		
e Mar	Director	Maryland Charles	Waldo					1 □ Yes 2 🔀	No	
with th	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?		
ns 23	Funeral	4085 Old Washington Road 11. Marital Status 12. Was Decedent	Ever in U.S.	20602 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sr	ecify Yes or No-	14. Race - Ame			
after o		1 Never Married 2 Married 1 Yes 2 M	No	If Yes, specify Cu		Hican, etc.)	Black, Whit	_{te, etc.} hite		
hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a	. Decedent's Usual Occi	upation	16h	. Kind of Business			
nin 72 e. an "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5		(Give kind of work don- life. DO NOT use retir	e during most of work red)	ina	uthern Ma	•		
ed with	Completed	12th.		elf Employe	_	e (First, Middle, Maid	Crane			
d be fill ental h red ott	Be	17. Father's Name (First, Middle, Last) Frank Lundholm				Maiden Un				
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examirer must be redified at	ျှ	19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing Address (Stree				Zip Code)		
and 2 lealth a m 27 is		Betty Keller/ wife	40	085 Old Was	hington Ro	. Waldorf	, MD., 20	0602		
Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State		f Disposition (Name of ry, crematory or other pi			Location - City or			
		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee	Trinit	zy Memorial 22. Name and Add		<u>il 28, 200</u> Intt Funera		rf, MD.	_	
permit. Departr Imports any Inje		Kieuta DIM mo	1284	3035 01d		Rd., Wale		. 20601		
		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do i ne.	not enter the mode of d	ying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	1	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ever	of AU	NOWE	M		+ Men		
Examiner		Nho	a consequence	CA Cha	WIN	Ri		~ Mai	H	
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w requires that the described speen signed by the should be detached	þ	Part II. Other significant conditions contributing to death b	out not resulting in	n the underlying cause (given in Part I.		co use contribute t	to the cause of death?		
v requi	Completed					24a. Was an		autopsy findings availa		
The faw te has age 2 s	дшс					autopsy performed	prior to death?	completion of cause	of	
stifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	Q 0 1⊡1e	5 2 1140		
Physic this co		1 ☐ Yes 2 BNo Hospital: 1 ☐ Inpati		utpatient 3 DOA	Other: 4 Nursing H	ome 5 Residence	e 6 Other (Sp	ecify)		
nding th. : After e funer	ition	27. Manner of Death 1 Natural 5 Pending (Month, Death of Injury) 2 Accident investigation	ay, Year)	Injury W	ork? □Yes 2□No	Zou. pescribe now i	njury occurred			
r Atter er dea rector	Certification: To	3 ☐ Suicide 6 ☐ Could not be 28e Place of In	jury - At home, fa tc. <i>(Specify)</i>	arm, street, factory, offic	е	28f. Location (Stree City or Town, S		Rural Route Number,		
pital o turs aff eral Di		29a. Certifier 1 Certifying Physician: To the best	of my knowledge	a death occurred at the	time date and place	and due to the caus	se(s) and manner	as stated		
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the by	Medical	(Check only one) A Medical Examiner: On the basis one)	of examination ar	nd/or investigation, in m	y opinion, death occu	rred at the time, date	and place, and du	ue to the cause(s)		
To the vithir comp	Me	29b. Signature and title of certifier	<u></u>	29c. Lice	ense number	29d.	Date signed (Mor	nth, Day, Year)	,	
)		ZMAN	W (-	7) [) 200	004	4/2	1109		
BB5		30 Name and address of person who completed cause of	death (Item 23a)	(Type, Print)	JMUN	WA	Dor.	isspM.	500	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

			For State of Maryla 1 - State Registrar	•	rtificate of L			Reg. No.	9 15102
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	Day Yea	3. Time of Death 16/4 M
	/Medic	al	SHIRLEY ANN LOWERY 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Hom	4c. County of De	
	Examin	er	WASHINGTON COUNTY HOSPITAL			GERSTOWN			SHINGTON
ı	Funeral		1 □ M 2 N E	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		213-40-4431 Usual Residence of Decedent	69 TIS.			APRIL 2	, 1940 1	MARYLAND
	arylan show	_	10a. State 10b. County 10c. (City, Town or Lo	cation				10d. Inside City Limits 11 Yes 2 □ No
	the Ma 28a-f	rectc	MARYLAND WASHINGTON 10e. Street and Number		BOON 10f. Zip Code	NSBORO		10g. Citizen of What	
	h with	al Di	15 YOUNG AVENUE		·	21713		U.S	S.A.
	r deat tems ?	Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ai Black, Wi	merican Indian, nite, etc.
0030	be filed within 72 hours after death with the Maryland Ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Eventhar must be notified at	þ	1 ☐ Never Married 2 ፟ Married 1 ☐ Yes 2 █ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1∐Yes 2⊠No	Specify:		Specify:	WHITE
5	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	during most of work	king	16b. Kind of Busines	ss/Industry
7	within ene.	Jup	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired TEACHER) -		DAY	CARE
פ	al Hygi other	Be Co	17. Father's Name (First, Middle, Last)	1	TEACHER	18. Mother's Nam	e (First, Middle,	Maiden Surname)	OTHE
ylar	should be and Ments s marked umatic ev	70	BOYD FREDERICK MONNINGER			DOROTHY			
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) DONALD E. LOWERY/SPOUSE		ng Address <i>(Street a</i> COUNG AVEN			er, City or Town, State MARYT AND	e, Zip Code) 21713
e,	es 1 an of Heal fitem 2 rother		20a. Method of Disposition 20b		sition (Name of matory or other plac		Date	20c. Location - City	
allimo	0		1 I Burial 2 XI Cremation 3		CREMATOR		2/2009	FREDERICK,	MARYLAND
פפו	permit. Pag Department Important: I any injury o		21. Sign rture of Funeral Service Lior nisee)oan	2. Name and Addres	15F		FFER FUNER	
			23a, Part 1. Enter the disease, or complications that caused the de					onsboro, M	Approximate
	Physician	8 4	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	m 7	CAGALT.	10~			Interval Between Onset and Death
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	Attend death ctor:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - A	t home, farm, str		Yes 2□No			Rural Route Number,
5	tal or safter al Dire	Certification: To	4 normale building, etc. (Spe				City or To		
	Hospi 24 hour Funer stely fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my lead one one of the control of the basis of examiner.	knowledge, deat iination and/or ir	th occurred at the til evestigation, in my c	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Med	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Me	onth, Day, Year)
			William & Country	1. mo	Do	051395		04/29/	2009
ム	4-5		30. Name and address of person who completed gause of death (I	tem 23a) (Type,	Print)		117/ 100	11/2-2-	2009 21742 70WM, MO
J1	Sta	te	WILLIAM E ROYS PEN JA. MD 1/11 31. Date filed (Month, Day, Year) 32. Progistrar's Sig	gnature	ICAR CAMP	120, 3	11/6/01	THEERS	011,70
	Registr		APR 3 0 2009	1.	ad				

DHMH 17 Rev 1/2001

4b. City, Town, or Location of Death

15103

1:45 AM

3. Time of Death

2. Date of Death Month Day April 26, 2009

4c. County of Death

1			11550 Stewart	Lane #608			Silver	Spring		Mon	tgomer	У
	Funeral Director		5. Social Security Number 262–52–9667	6. Sex 1 ½ M 2□ F	7. Age (<i>In yr</i> s. 69		If Under 1 Yea Months Days		Irs. 8. Date of Bi (Month, Do	rth a <i>y,</i> Year) 1939	9. Birt Co Geo:	hplace (State or Foreign ountry) rg1a
	and w		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	0	MD Montg			ver Sp						1 □Yes 2XNo
	the N	rect	10e. Street and Number	Office y	511	.ver bp	10f. Zip Code			10g. Citiz	en of What Co	untry?
	3a or	O E	11550 Stewart	Lane #608			20904			USA		
	death	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No Lerto Rican, etc.)	0- 1-	4. Race - Ame Black, White	
36	after or ite		1 Never Married 2X Ma	rried 1X Yes	2 □ No		1 ⊡Yes 2 X DN		10110 / 110411, 010.7		Specify:	
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15	n 72 n mat	olete	(Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occ kind of work don DO NOT use retii	e during most of	working	TOD. KIN	d of business/	Hidustry
21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ty Offic	cer	U.S.	Navy	
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€,	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic		Patricia A. Le	May/ Wire	l ook r				608 Silve	,	ation - City or	
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Ba	permit. Pages 1 Department of I Important: If ite any injury or of		21. Signature of Funeral Service	e Licensee	_ MO1				tion Serv			ox 784 <u>le, MD 21029</u>
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	/Medical	Ш	disease or condition resulting in death)	al.	nageal C							0 morrers
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Box	eath certific attending p for use as i	2	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		□ Fotonio progno	ma		2	3d. Date of de	
	deat he att	sicia	in the past 12 months? 1 ☐Yes 2 ☐No		birth 2 ☐ Feta gnant at time of o		☐ Ectopic pregna ☐ Other (specify)				Month	Day Year
P.0	at the de d by the etached	Phy	9 Unknown			lai i al		-in in Doubl	220 Did	tohoono us	o contribute t	o the cause of death?
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900	The law requir ate has been s page 2 should I	Complete							24a. Wa		24b. Were a	utopsy findings available completion of cause of
Ä	: The bate had page	E							— auto peri 1 □Yes	opsy formed? 2 2 No	death?	s 2 No
/ita	slcian: Th certificate rector, pag	Be C	25. Was case referred to medic examiner?	al				26. Place of	Death (Check only			
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n c	ding P h. After funera	io ::	27. Manner of Death 1X Natural 5 ☐ Pend	ing .	of Injury oth, Day, Year)	28b. Time o Injury	W	ork?	28d. Describe	how injury	occurred	
Division	death death stor: / the	Certification:	3 ☐ Suicide 6 ☐ Could		e of Injury - At h	ome farm str	M 1 reet, factory, office	□Yes 2□No	28f Location	(Street and	d Number or F	Rural Route Number,
Ďi	after d after d Direct d in by	ertif	4 ☐ Homicide deter	mined 286. Flact build	ling, etc. (Speci	ify)	cot, tactory, onto		City or To	wn, State)	2144111501 01 71	10/4/ 110010 / 12011 21/
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	To the within 2 To the comple	Me	29b. Signature and title of certific	7			29c. Lice	nse number		29d. Date	e signed (Mon	th, Day, Year)
				1	- n	1. D.	VA01	0124015	0	04/2	27/09	
	221)		30. Name and address of pers									
_	5/13	1 1	Clifton C. Mo,	M.D. 6900	Georgi	a Ave.	NW Wash	nington,	DC 20307			
	Sta Registi	ite rar	31. Date filed (Month, Day, Yea,	8 2009	egistrer's Signa	ature.	and					
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signed by the atte à Completed has s certificate h rector, page Be this ۵ After Certification: within 24 hour after ceath.

To the Funeral Director: A completely fill d in by the fu

Division of Vital Records, P.O.

ceath.

(Disease or injury that initiated	C	
events resulting in death) Last	Due to (or as a consequence of):	
▼ UNPENDED	d. X AMENDED #1 as noted, 23a,27,28a-f,perME	c, g893 7/14/09 TT
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknow	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery cy Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26 Place of Death (Check or	níy one)
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, Nursing	Home 5 Residence 6 ✔ Other: Scene

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

Fd 5/1/2009 Fd 5:30 pm

21th 30. Name an address of person who completed cause of death (Item 23a) Assistant Medical Examiner Margarita Korell MD.

28a. Date of Injury (Month, Day, Year)

(Specify) house

111 Penn Street, Baltimore, MD 21201

28c. Injury at Work?

29c. License number

O.C.M.E

Yes 2 X No

31. Date filed (Month, Day, Year)

29b, Signature and title of certifier

1 🗸 Yes

27. Manner of Death

3 ___ Suicide

2

Medical

Natural

Accident

Homicide 29a. Certifier 1

2 No

Pending

6 X Could not be

Investigation

determined

Registra

May 2, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State) / 813 W . HILL Rd

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Mt. Airy, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15/05 Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 9:40 PM Sandra Kay Layman April 2009

Physician

	Exami	ner			give street and nur				or Location of Death			ounty of Dea	
					orial Hos				derick			reder	
	Funeral		5. Social Security I		3. Sex 1 ☐ M 2 🔀 F		yrs. last birthday Vrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth Pay, Year)	C	thplace (State or Foreign ountry)
	Director		235-66-4333 Tuli M 21XF 65 Yrs. Usual Residence of Decedent							Aug 15	, 1943	West	Virginia
	and		10a. State	10b. County		10c.	City, Town or L	ocation					10d. Inside City Limits
	Manyl f sho	ō	Maryland	Freder	ick		Walkers	ville					Y⊡Yes 2 No
	the t	rec	10e. Street and Nu				- TOTAL	10f. Zip Code			10g. Citize	n of What Co	ountry?
	with 3a or	Ö			ick Stree	t		21793	3		USA		
	death ms 2	Jera	11. Marital Status		12. Was Dece	dent Ever in	n U.S. 13	. Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or N	0- 14		erican Indian,
9	after or Ite	Ē		ried 2 Marrie	d 1 ☐ Yes	2 🔀 No				o Rican, etc.)		Black, Whit	e, etc. 7hite
03	ral", c	by	3 🗆 Widowed	4 Divorced	If Yes, Giv Year or Da	re ates:		1 □Yes 2K No	Specify:		S	pecify: W	MILCO
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or Items 23a or 28a-f show ent, the Medical Exemirer must be notified at	Completed by Funeral Director	(Spe	15. Decedent's	Education grade completed)		16a. Dec	edent's Usual Occu	pation during most of work	king	16b. Kind	of Business	/Industry
121	ithin ne. han "	Ig II	Elementary/Sec		College (1	-4or 5+)	life.	DO NOT use retire	ed)		 		1.
2	led w lygie her t		12 17. Father's Name	/First Middle L	and!		Sale	<u>s</u>	18. Mother's Nam	o (Eiret Middle	1		. supplies
and	ntal Hed of	Be		Chapman	251)					ine Woo		amamey	
Ë	should be filed within and Mental Hygiene. 8 marked other than umatic event, the Ma	ျ	19a. Informant's N		- (Time Drint)		10h Mai	line Address (Ctros	et and Number or Ru			Four State	Zin Codo)
Maryland	d 2 sho th and I 7 Is ma trauma		Ronald I				I	•					ryland 2179
	1 and 2 Health tem 27 l		20a. Method of Dis		nasbana	20		position (Name of ematory or other pla		Date		ation - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at any Injury or other traumatic event, the Modical Examiner must be notified at any once.		1 ☐ Burial 2	•	Removal from	Siaig		ematory or other pla Cremator	i		Fred	erick	Maryland
Ħ	artme ortan Injur		21. Signifure of F			/ 10			ess of Facility Sta	L 24,09			
Ba	permi Depar Impor any Ir		MANA	24) 60	111.	1/1 -	1	621 Oposs	Sta sumtown Pi	ke. Fre	runera ederic	i ноте k. Mar	vland 2170
	-		23a. Part 1. Enter	the disease, or o	omplications that co	aused the d			ring, such as cardiac				Approximate Interval Between
	Physician	3.7	Immediate Cause	(Final	nly one cause on e	ach line.					Onset and Death		
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):								-		
Т	Examiner										1		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
	cuted nd ransit	Ē											
o,	an ar rial-tı	Ğ	Due to (or as a consequence of):										
Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical		•	d								
39 3	ertifica ing pl	Med	IF FEMALE:							5E:			
ã	eath certific attending p for use as t	an/l	23b. Was deceder			oirth 2 🗀 F	Fetal death 3	☐ Ectopic pregnar	псу		23	d. Date of de	elivery Day Year
	at the dea by the a tached fo	sici	1 ☐ Yes 2 9 ☐ Unknow	⊠ No	4 ☐ Pregr 9 ☐ Unkn	nant at time own	of death 5	Other (specify)				MOHAT	Day Teal
P.0.	that the ed by detacl	Ph			e contributing to de	ath but not	regulting in the	underlying cause g	iven in Part I	23e Did	tobacco usi	e contribute t	to the cause of death?
ds,		b	Part II. Other sign	inicant condition	s contributing to de	saur but not	resulting in the	andenying cause g	iven in raiti.		1111		Probably 4 ☐ Unknown
0.0	The law requires ate has been slgn bage 2 should be	Completed	1								-		
3ec	e la	ם							<u></u>	24a. Wa	opsy	prior to	utopsy findings available completion of cause of
a		ខ								1 □ Yes	formed? 2 🗷 No	death? 1 ☐ Ye	s 2□No
Vital Records	Physician: this certific ral director,	Be	25. Was case refe examiner?		Hospital:			100	26. Place of Dea	th (Check only	one)		
ō	Phys this al dir	은	1 ☐ Yes 2 ☐ 27. Manner of Dea	-	1 281		2 ER/Outpati 28b. Time	ent 3 L DOA	4 ☐ Nursing H				ecify)
n	Ilng After	io	1 🗑 Natural	5 Pending	· ·	th, Day, Yea		Wo	ork? □Yes 2 □No	28d. Describe	a now injury	occurred	
isi	Attending r death. sctor: After by the funer	icat	2 ☐ Accident 3 ☐ Suicide	investiga 6	the l	of Injury - A	At home farm s			28f Location	(Street and	Number or F	Tural Route Number,
Division	I or Attencate after death Director:	Certification:	4 🗌 Homicide	determin	ed buildi	ng, etc. <i>(Sp</i>	pecify)	treet, factory, office		City or To	own, State)	riamber or r	arar riodio ridilibor,
_	Hospital 24 hours a Funeral tely filled		29a, Certifier	1 Certifying	Physician: To the	best of my	knowledge, de	ath occurred at the	time, date and place	e, and due to th	e cause(s) a	and manner a	as stated.
	24 h 24 h e Fur letely	Medical	(Check only one)	2 Medical E	xaminer: On the b	asis of examer stated.	mination and/or	investigation, in my	opinion, death occu	rred at the time	e, date and p	lace, and du	e to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b	Me	29b. Signature and	d title of certifier		_		29c. Licer	nse number		29d. Date	signed (Mon	th, Day, Year)
	, , , , ,			1	nn			MD]	D62471		4	122/	99 .
	7		30. Name and add	dress of person w	ho completed caus	e of death ((Item 23a) (Type	e, Print)			-1	-	
B	3			Abbas, M					Frederick	, Maryl	and 2	21701	
	St	ate	31. Date filed (Mo.	A Cata Car	111	egistrar's Si	ignature.	backer					
	Regist	rar	l	APRZI	ZUUS LA	year and	101 19						

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State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Ma	•		tificate of L		vientai my	Reg. N	/11	09	151	06
Н	Physicia	an	1. Decedent's Name (First, Middle,	Last)	_				2. Date of De Month		ay	Year	3. Time of De	
	/Medic		Frances A. Meade				dh Cihi Tourn or	Location of Death	April		2009 c. County o	of Death	6:30	a M
	Examin	er	4a. Facility Name (If not institution,				Silver S				Montgo			
	Funeral		Holy Cross Hospi 5. Social Security Number 6	. Sex 7. Age	(In yrs. last birth	nday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth			place (State or F	Foreign
	Director		235-50-3522	1□M 2] [F	72 Y	rs.	WOTHING Days	Tiodio Willi.	Aug 17,				WV	
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation					1	0d. Inside City	Limits
	Maryl -f sho fied a	tor	MD Montgom	ery	Wh	eato	n						1 □Yes 2	⊠ No
	h the or 28a o notir	Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of W	hat Cour	ntry?	
	tth wit 23a c ust be	ral	11507 Veirs Mill				20902				USA			
5-0036	be filed within 72 hours after death with the Maryland at Hygiene. And	by Funeral	11. Marital Status 1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba □Yes 2 X No		pecify Yes or N o Rican, etc.)	0-		, White,		
2 D	72 hou natura lical E	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a.	Deced (Give I	ent's Usual Occup kind of work done o	ation during most of wor	king	16b.	Kind of Bus	siness/In	dustry	
7	/ithin ine.	mple	Elementary/Secondary (0-12)	College (1-4or 5+			O NOT use retired as ing Agent			F	rintin	9		
7	filed within Hygiene. other than "		12 17. Father's Name (First, Middle, La	ist)				18. Mother's Nan	ne (First, Middle	e, Maide	en Surname	=)		
land	ld be lental ked o ic eve	To Be	William V. DeBer					Maude	Ethel Fr	azie	er			
ary	2 should be and Mental Is marked raumatic ev	۲	19a. Informant's Name/Relationshi	(Type. Print)	19b.	Mailin	g Address (Street	and Number or Ru	ıral Route Num	ber, Cit	y or Town, S	State, Zij	Code)	
≥	12 # S		Merton O. Meade, 3	r. /Husband			Veirs Mill							
gaitimore,	Page: ent o nt: If ry or		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 4 ☐ Donation 5 ☐ Other (Specific Control of			itar	sition (Name of latory or other place n Crematory	April	27, 2009	Al	Location - (ia, V	A	
Rail	permit. Departm Importa any inju		21. Signature of Funeral Service Li	censee for the first	-	14	Name and Addres Universit	11					Home Inc	c.
			23a. Part . Enjer the disease, or c	omplications that caused	the death. Do n			·			, 110 2	0301	Approximate Interval Between	een
	Physician		shock, of heart failure. List of Immed 15 Cause (Final disease or condition	Lung Ca									Onset and De	eath
	/Medical		resulting in death)	Due to (or as a	consequence o	f):								
	Examiner	<u>_</u>	Sequentially list conditions,	b. Due to (or on	consequence o	.f\.						_		
_	rted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of hijfury	Due to (or as a	consequence o	1).								
ر ح	execu nn and ial-tra	Examiner	Cause (Disease of injury that initiated events resulting in death) Last	c Due to (or as a	consequence o	of):								
68/6 0,	ificate be executed g physician and as the burial-transit	edical		d										
	ertifica ling pl e as t		IF FEMALE:	One Wayne systems of			-			-				
.c. Box	w requires that the death certif been signed by the aftending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal death		Ectopic pregnand Other (specify)	у			23d. Date Moi		,	ear
ν, T	s that gned b e deta	by Pt	Part II. Other significant condition	s contributing to death bu	t not resulting in	the ur	iderlying cause giv	en in Part I.	23e. Dio	tobacc	o use contr	ibute to	the cause of de	ath?
ecords,	equire sen siç ould b		-						1	Yes	2 No	3 √ Pro	bably 4 ☐ Ur	nknown
Hec Hec	The la	Completed							24a. Wa aut per 1 □Yes	opsy formed	? p	rior to co leath?	opsy findings av ompletion of cau 2 No	vailable use of
<u> </u>	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo	Hospital:			t 3 🗆 DOA Oth	er: Dece of Dec			0 000	(0	"	
0	this ald	۳. ا	27. Manner of Death	28a. Date of Injur	nt 2 ER/Out	ime of	28c. Injur	y at	lome 5 ☐ Re 28d. Describ				ny)	
0	ath. rr: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		, rear)	njury	M 1 □	Yes 2 □No						
DIVISION	tal or Attending F s after death. al Director: After ed in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, far . <i>(Specify)</i>	m, stre	eet, factory, office		28f. Location City or T	(Street own, St	and Number ate)	er or Rui	al Route Numb	er,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1	Physician: To the best of xaminer: On the basis of and manner sta	examination an	, death d/or in	vestigation, in my o	opinion, death occ	e, and due to thurred at the time	e, date	and place, a	and due	to the cause(s)	
	Jo with The Market	Σ	29b. Signature and title of certifier	111	*		29c. Licens		>	29d.	Date signed	(Month	, Day, Year)	
	5 (5)		as Name and address of	1 Jel	ath (Itam 000)	2 C		64588		7	10	1/6	/-	
-			30. Name and address of person w Ashish Tolia, 15	•				20910						
	Sta Registr		31. Date filed (Mohth, Day, Year)		r'e Signature		Led.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 6:50 РΜ 2009 22, April Eugene Godfrey Mower, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours XXM 2□F Months 1922 Washington, DC 30, 86 Apr. 577-22-0394 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 21 No Berlin Maryland | Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. #10 Coastal Drive 21811 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1XXYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Mayes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 🔼 No WW II 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Helen Liming Eugene Godfrey Mower, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Mower / Wife #10 Coastal Drive, Berlin, Maryland 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/29/2009 Rockville, MD Parklawn Cemt. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 Williams Street, Berlin, Maryland 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a construence of): disease or condition resulting in death) Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Renal Heute Due to (or as a consequence of) Uncontrolled IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

0

"natural"

than

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if item 27 is marked other tha any injury or other traumatic event, Ital 2008.

Baltimore, Maryland 21215-0036

Director

Funeral

ð

Completed

traumatic event, the Medical Exaction must be notified at

ending physician and use as the burial-transit the attending p detached

Physician/Medical

₽

Completed

Be

Certification: To

Medical

State Registrar

reate has been signed by to page 2 should be detach certificate has

P.0. Records, Vital funeral director, þ After this Division death. To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the completely

GENE

EU

11/2 CS8

BA 3+1

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

29b. Signature and title of certifier Attending) 30. Name and add as of person who completed cause of dea (Item 23a) Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

22 APRIL 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9733 Hoalthway Drive Berlin, MD 21811 Stammas, MD

investigation

6 Could not be determined

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

renta Vondal McF	arland State of Maryland / Department of 1- For State Certificate of Registrar	Death Reg. No. 2009 51
Physician/ edical Examiner	1. Decedent's Name (First, Middle,Last) Larenta Vondal McI	2. Date of Death Month Day Year 2122 hrs Farland April 19, 2009
	4a. Facility Name (if not institution, give street and number) Rt. 214 & Campus Way South	bb. City, Town, or Location of Death Landover 4c. County of Death Prince George's
Funeral Director	5. Social Security Number 216-25-7655	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country) 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 10/02/1989 1
/any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on 10d. Inside City Limits
the Maryland a or 28a-f show tiffed at once.	MD Prince Georges Landover 10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
n with the Mar. ms 23a or 28a be notified at eral Direc		20785 S Decedent of Hispanic Origin? (Specify Yes or Noes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
s after death with rral", or items 23 niner must be no by Funeral	3 Widowed 4 Divorced of Divorced of Dates:	Yes 2 No specify: Specify: Black at's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
OO36 within 72 hours giene. her than "natu her dan gate Medical Exau ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 11th Sale:	ost of working life. DO NOT use retired) s Associate Private
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Derek Lee Hill	18.Mother's Name (First, Middle, Maiden Sumame) LaWander T. McFarland
MD 21: nd 2 should be the and Mer m 27 is man aumafic eve	LaWander T. McFarland/ Mother 6331	G Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Landover Rd. #202, Landover, MD 20785 Sition (Name of cametery, Date 20c. Location - City or Town, State)
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	1 Burial 2 X Cremation 3 Removal from State Riverdal	ther place) e Park Crem. 4/27/2009 Riverdale, Maryland
Balti permit. Departir Imports injury e	21. Signature of Funeral Service Licensee	Name and Address of Facility Johnson & Jenkins Funeral Home 6 Kennedy St. NW, Washington, DC 20011 The mode of dring such as cardiac or respiratory grest, shock, or heart Approximate Intervention.
Physician Medical kaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Between Onset and Death
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ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
e be executed sysician and burial - trans	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Contification: To Be Completed by Physician/Medical Experience.	23b. Was decedent pregnant in the past 12 months? 1	retal death 3 Ectopic pregnancy Month Day Year Other (Specify)
cords, P.O. Boy aw requires that the death has been signed by the att 2 should be detached for principled by Dhyesi		underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.C. tat or Attending Physician: The law requires that is after death. "In Director death. In Director of the this certificate has been signed feel in by the funeral director, page 2 should be deticating that the contribution of the death of the contribution of the death of the contribution of th		24a. Was an autopsy findings availate prior to completion of cause of death? 1 Ves. 2 No. 1 Ves. 2 No.
tal Rection: The certificate ector, page		1 ✓ Yes 2 No 1 ✓ Yes 2 No 26 Place of Death (Check only one)
Vital hysicians this certi	examiner? Hospital: Innetion 2 FR/Outpaties	
ision of Vital Rec Attending Physician: The I redeath. et or After this certificate by the funeral director, page	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Apr 19, 2009 28b. Time of 2107 hrs	f Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Pedestrian struck by auto
Division of spiral program of spiral or Attending hours after death. meral Director: After y filled in by the funer	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Highway	reet, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cor Town, State) Rt. 214 & Campus Way South, Landover, MD
To the Hospital within 24 hours a To the Funeral completely filled		curred at the time, date and place, and due to the cause(s) and manner as stated. pation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	29b. Signature and title of certifier While Brasse (IN)	29c. License number 29d. Date signed (Month, Day, Year) April 20, 2009
		Penn Street, Baltimore, MD 21201
Stat Registra		

09-03566 Kenneth Neff Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 15109

		- For State	Cei	rtificate of	Death			Re	g. No	000	
Physicia		Registrar 1. Decedent's Name (First, Middle,La	st)					Date of Death Month	Day Year	1	ime of Death 345 hrs
edical Exami	ner	Kenneth	David	Neff				May 3, 200	9		345 HIS
		4a. Facility Name (if not institution, gi		4	b. City, Town, o	r Location of I	Death		4c. County of		
		11121 Montana Avenue			Lavale				Allegany		
Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea		24Hrs. Min.		n(MM/DD/YYYY)	Foreign	Maryland
Director		216-80-3599	M 2 F 47	Yrs.	Months Day	ys Hours	MIII.	12/21/	1961	Country)
	ŀ	Usual Residence of Decedent								140	Links City Limits
any	Ī	10a. State 10b. County	10c. City	, Town or Locati	on						I. Inside City Limits Yes 2 X No
ž .	_	MD Alle	gany	Fr	ostburg	S				1	Yes 2 ANO
Aaryland 28a-f show	윐	10e. Street and Number			10f. Zip Code			10	g. Citizen of Wh	at Country?	
ith the Mary	Director	10412 Borden	Road		2	1532		ļ	US	A	
with the Maryland ns 23a or 28a-f sho		11, Marital Status	12. Was Decedent Ever in U	J.S. 13. Wa	s Decedent of H	lispanic Origin	n? (Spec	cify Yes or No		- American	Indian, Black,
ath v item	uneral	1 Never Married 2 Marrie	Armed Forces?	If Y	es, specify Cuba	an, Mexican, F	Puerto Ri	ican, etc.)	AATIILE	i, etc.	ł
ter de	ഥ	3 Widowed 4 X Divorce	d If Yes, Give Year	1	Yes 2 X N	lo specify:			Specify:		ite
ırs af tural	ğ	15. Decedent's Education (Specify	or Dates:	16a. Deceder	it's Usual Occup	ation (Give ki	nd of wo	rk done	16b. Kind of Bu	siness/Indus	stry
2 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working lit	ie. DO NOT u	126 16016	u)			1
36 thin 72 than than edical	d	11		La	aborer					struct	ion
d wil	Ö	17. Father's Name (First, Middle, Las	st)			18.Mother's	Name (First, Middle, I	Maiden Surname)	
21215-0036 suld be filed within 72 hou Mental Hygiene. marked other than "naf ic event, the Medical Exa	Be (Frank	Delano	Neff, S	Sr		andra		Jean		ibley
21 Duld bould b Mer mar ic eve	٥	19a. Informant's Name/Relationship	(Type, Print)						nber, City or Tow		Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tenal hand hendral Hygien American Tis marked other than "matural", or items 23a or 28a-f site traumatic event, the Medical Examiner must be notified at once		Nina R. Neff /							21543 20c. Location	City or Toy	un State
imore, MD 2 Pages 1 and 2 shou ment of Health and N lant; If item 27 is n or other traumatic		20a. Method of Disposition		. Place of Dispos	sition (Name of o ther place)	cemetery,		Date	200. Location	- City or Tov	vii, State
nor ages ant of at: II	М	1 Burial 2 X Cremation 3 4 Donation 5 Other Speci	I ():	umberlar	nd Crema	atory	05/	05/200	Cumbe	rland	, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other It injury or other traumatic event, the Med		21 Signature of Funeral Service Lic	ensee /	22.	Name and Addre	ess of Facility	Ada	ms Fam:	ily Fune	ral H	ome, P.A.
Balti permit. Departri Import	1	LIGHT Y (Ido	m						perland,		21502
Physician		25a. Part I. Enter the disease, or cor	nplications that caused the dea	th. Do not enter	the mode of dyir	ng, such as ca	ardiac or	respiratory ar	est, shock, or he	art	Approximate Interval Between Onset and
/Medical	0.3	failure. List only one cause on Immediate Cause (Final disease	a. Atheroscle	rotic Ca	rdiovas	cular	Disc	2286			Death
aminer	ı	or condition resulting in death)	Due to (or as a consequence								
		Sequentially list conditions,	b			_					
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	e of):						1	
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):							
xecuted n and - transit			d								
ਤਾੜ ਦ	Medical	X UNPENDED	AMENDED 23a,27	7 per me	g892 6	-11-09	vt				
760, icate be exe	l de	IF FEMALE:	23c. If yes, outcome of pr	egnancy				100000	23d. Date of	·	
187 rtifica ing p		23b. Was decedent pregnant in the past 12 months?	1 Live birth	d -th-	etal death	3 Ectopic	c pregnai	ncy	Month	Day	/ Year
Box 687 death certific the attending 1 ed for use as the	Sicia	1 Yes 2 No 9 Unkno	Pregnant at time of	death 5	other (Specify)						
Be de:	1 ~	Part II. Other significant condition	9 OHKHOWH	at resulting in the	underlying caus	se given in Pa	art I.	23e. Did	tobacco use con	tribute to the	e cause of death?
ords, P.O. I we requires that the as been signed by t	J S	Part II. Other significant condition	is continuoung to death but no	7. 1000 mily				1 Y	es 2 No 3	3 Probat	oly 4 🗸 Unknown
S, F uires n sign Id be	Po							24a. Wa	s an 24b	. Were auto	psy findings available
ord w req s bee	l je								opsy formed?	prior to cor death?	npletion of cause of
ecc he lav ate ha									2 No	1 🗸 Yes	2 No
tal Rection: The certificate ector, page	C	25. Was case referred to medical	1		26.PI	lace of Death	(Check	only one)			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death In Director: After this certificate has been signed by leaf in by the funeral director, page 2 should be deated.	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other ₄	Nursin	g Home 5	Residence 6		Scene
n of ving Physical After the Physical After the Physical After the Physical Action (1997).	۱۵		28a. Date of Injury (Month, Day, Year)	28b. Time o	·	Injury at Work	¬	28d. Describ	e how injury occu	ırred	
on endin ath or: A	₫	1 X Natural 5 Pendin	g		1	Yes 2	No				
rision ratte	<u> </u>	2 Accident Investig	28e Place of Injury - A	t home, farm, st	reet, factory, offi	ce building, e	tc.	28f. Location or Town		nber or Rura	Route Number, City
Div ital o irs affi	Certification:	4 Homicide determ						0.2			
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Functari Director: After this certificate has been signed by the attending Tro the Punctari Director: After this certificate as should be detached for use as to	Ú	29a. Certifier (Check only 1 Certifying Phy	sician. To the best of my know	ledge, death occ	curred at the time	e, date and pl	ace, and	due to the ca	use(s) and manr	ner as stated	i.
thin 2	edical	one) 2 Medical Exam	iner:On the basis of examination and manner stated.	n and/or investig	gation, in my opi	nion, death o	ccurred a	at the time, da	te and place, and	a due to trie	
- To wit	Me	29b. Signature and title of certifier	A CONTRACTOR CONTRACTOR		29c. Lic	ense number		CME			h, Day, Year)
		1/1/11/11	6		0	.C.M.E.	U	OTVIE	May 4, 2	009	
		30. Name and address of person w	ho completed cause of death (I	tem 23a)							
		Theodore M. King, Jr.,			111 Penn	Street, Ba	altimor	e, MD 212	01_		
والمناوات	i Stat	31. Date filed (Month, Day, Year)	OO Degistlerie Cig	nature	1	,					
	istra	MAV 1	1 2009 Burns	M.	Barker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 8:22 AM April 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Age (In yrs. last birthday) Days 0971371954 California 54 226-86-9040 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No **Elkridge** Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 21075 6514 New Castle Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yes If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify White 3 Widowed 4 X Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Musician/Luthier Music 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Joan Mary Scarth Robert Edward Ollweiler 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3069 Timberwood Lane, Moneta, Virginia 24121 Robert E. Ollweiler/Father 20b. Place of Disposition (Name of cometery, crematory or other place)
Kalas Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 04/23/2009 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fund at Service Licenses 22 Name and Address of Facility George P. Kalas Funeral Home tu 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death weeks Die to (or as consiquence Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 2 No Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

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Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than 'riatur any injury or other traumatic event, the Medical once.

Examiner

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical ò Completed Be မ

Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 2 🗍 No Yes 2 | No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1 Tes 2 No 1 Inpatient 3 🗆 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) 27. Man or of Death 1 Natural . Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide determined Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number Res-000 29b. Signature and title of certifier

State

Registrar

SHAUNE RAO, NI 31. Date filed (Month, Day, Year) APR 23

Régistrar's Signature

, MP

20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Division of Vital Records, P.O. Box 68760,

				e Type or Prir					-		_	
		For State	Amend It	State of Maceus 23aPt1	aryland	27 Depa	artment of h	lealth and less good	Mrntalday	giene	2000	15111
		1 - State Registrar 1. Decedent's Nam			_	Ce	rtificate of	Death	2. Date of De		2003	O Time of Death
Physicia	an	Dorothy M		,						26, Day	nng Year	3. Time of Death 9:05 a M
/Medic Examin				give street and number)			4b. City. Town, o	r Location of Death	<u> </u>		County of Death	9.03 a
Examin	er	6648 Buck					Bryans F	-			Charles	
Funeral		5. Social Security N	lumber 6	- T.F.	e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Birthp	place (State or Foreign
Director		577-46-40		1□M 2 X F 7	5	Yrs.	World Bays	Tiodio iviiii.	Oct. I	2, 19	33 Wash	ington D.C.
land		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
Mary I-f she fied a	tor	Maryland	Charles	5	Bry	ans R	oad					1XYes 2 □ No
h the or 28s	Director	10e. Street and Nu					10f. Zip Code			10g. Citiz	zen of What Cour	itry?
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, I'm "hidical Evaminer must be notified at	<u></u>	6648 Buck	mell Ro	ad			2061			U.S.	Α.	
tems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	 Race - Americ Black, White, 	
rs afte	by F	1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married	1 ∏Yes 2 📉 I If Yes, Give Year or Dates:	No		1 □Yes 2XINo	Specify:			Specify: Whi	te
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d Mei d Mei marke	ည	19a. Informant's N		(Time Duint)		40h Malli	A -i d (C4	_				Code
id 2 sl lth an 27 is r traum		Patricia		Daugh	ter		-	and Number or Ru L Road, B		-	•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at once.	0. 3	20a. Method of Dis		2 8				ce)April 29			cation - City or To	
Page:			☐ Cremation 3 5 ☐ Other (Spe	☐ Removal from State cify)	l l		ivet Ceme	- ;	5, 2005	Wash	ington I).C.
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equire een si	ed	Right	Hip Frac	ture					1 🗆	Yes 2	No 3 Prot	bably + Unknown
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sician certifi rector	Be	25. Was case referexaminer?	red to medical	Hospital:			oth	26. Place of Dea				
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nding ath. r: Afte e fun	atio	2 Natural 2 Accident	5 ☐ Pending investigat		1 <i>y, Year)</i> 3	Injury 3:30 ₁		rki?]Yes 2. X No	Subject	t fel	1.	
r Atte er de recto	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of inj	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location ((Street and	d Number or Rum	al Route Number, cknell Road
ital o Ins aft ral Di				Home					Bryans	Koad	, Maryla	and
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical Ex	Physician: To the best aminer: On the basis o and manner sta	of examination	ledge, deat on and/or in	h occurred at the ti vestigation, in my o	ime, date and place opinion, death occu	e, and due to the rred at the time	e cause(s) , date and	and manner as a place, and due to	stated. the cause(s)
o the vithin of the omple	Mec	29b. Signature and	title of certifier	and manner st	aleu.		29c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)
F S F O	i	> K	Most	t			02	835)	4-	27-0	9
0		30. Name and add	ress of person wh	no completed cause of d	leath (Item 2	23a) (Type,		1		,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) PROIA 22:10P.M **Physician** TRANCES MPR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD COUNTY GENERAL HOSPITA HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🛛 F 579-20-1978 Director Mar 21, 1914 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Experiment as the notified at 1 ∐Yes 2√∑No Director MD Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 6336 Cedar Lane #232 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. If Yes, Give Year or Dates: Specify: White \$ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Supply Store Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental and Menta Katie Estelle Grimes Jesse Thomas Baker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13630 Nichols Drive Clarksville, MD 21029 Donald S. Proia/son item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory 04/27/09 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Golfgan Hornes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION HOURS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to firm plat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed after death. burial-transit and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 MNo 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD, FCCP APR. 23, 2009 0 36845 nguyen, MD, FCCP 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) Men - Cln brive, 3 50 0 Cotumb MD 32. Registrar's Signature 31. Date filed (Month State 28 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Registered # 19b,5-4-09, per FHDR, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - ^{Day} 2009 April 26, **Physician** 10:07 РМ Georgia Mae Perkins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mt. Airy
Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth
Inths | Days | Hours | Min. | Sept 20, Frederick Kline Hospice House Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Maryland 1 □ M 2 🔀 F 61 Director 212-62-4704 Usual Residence of Decedent the Maryland 10d, Inside City Limits 10c, City, Town or Location 10a State 10h. County rral", or items 23a or 28a-f show Examiner must be notified at 1₽Yes 2□No Director MD Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21703 5820 Rosebay Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes X□No Baltimore, Maryland 21215-0036 Specify. Specify: White 2 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 7 Is marked other traumatic event, If 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Mildred Viola Jacobs Raymond Garfield Racey ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 W. Water Street Smithsburg. MD 21783 19a. Informant's Name/Relationship (Type. Print) Health a Eric E. Perkins/son Department of Health Important: If Item 27 any Injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 04/28/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 the Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): ucch 60 11-1 disease or condition resulting in death) /Medical **Examiner** = x6 =usice Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ♣No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>会</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed 1 ☐ Yes 2 ☐ No 1 Tyes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifio 29c. License number 127/7 14620

State

31. Date filed (Month, Day, Year)
APR 2 8 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Begistrar's Signature

A. Sauk

6- F-11-115 MO 21701

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Raymond L. Rogers 9:45a April 19, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1505 Red Oak Drive Montgomery Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1**XX**M 2□ F 577-09-4825 December 5, WV/ 96 1912 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at Silver Spring 1 ☐ Yes 2 No Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or USA 20910 1505 Red Oak Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 **X**]Yes 2 □ No If Yes, Give Year or Dates: **WWII** 1 Never Married 2 M Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify \$ 3 ☐ Widowed 4 ☐ Divorced 'natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Real Estate and Mental Hygiene. Broker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel M. Rogers Harriet E. Hagerty 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Red Oak Drive, Silver Spring, MD 20910 19a. Informant's Name/Relationship (Type. Print) and 2
...ent of Health au
ant: If item 27 is n Frances F. Rogers / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 permit. Page Department c Important: If any injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 23, 2009 Brentwood, MD Fort Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. West, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Ulsa Trevalo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed and that initiated events use as the burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month. Year for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 ☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 □Yes 2 K No 1 ☐ Yes 2 X No Division of Vital Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 🗌 Yes 2**X**No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D-5937

April 20, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Angeline Ann RUSSO 7:05 p. M 28, 2009 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 642 Knightsbridge Drive Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1 M 2 X F 82 192-20-4447 Pennsylvania Sept.7,1926 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ▼ Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with eath and Mental Hygiene. n 27 is marked other than "natural", or Items 23a or ? 21740 USA 642 Knightsbridge Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify white þ 3X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) her own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Sclafani Rasario Sclafani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Jackie Moyer - daughter 642 Knightsbridge Dr., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/4/09 St. Patrick's Cem. Norristown, Pa. 4 □ Donation 5 □ Other (Specify) 21. Sweature of Funer Lawrice - en 22. Name and Address of Facility MINNICH FUNERAL HOME W 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metostain Muchatu **Physician** Careinenna weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a poissequence of) Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the th as ed by the attending detached for use as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1☐ Yes 2 No death? 1 ☐ Yes 2 ☐ No certificate | Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 \sum Nursing Home Hospital: Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director: After t After 5 Pending investigation 1 Yes 2 No 2 Accident the 6 □ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated the within 7 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 28365 4-29-09 Mousen red Heastern 190 21740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

MAWZ AR OSHAPI 32. Registrar's Signature

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	Physician
.	/Medical
	Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventina instable healthed at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Division of Vital Records, P.O. Box 68760,

	for State Registrar			Olale C	I IVIC	ii yiai ii		ertificat				icitaiii	_	. No 2 0	09		5	16
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	Usual Residence of 10a. State	10b. Count	ty			10c. City	, Town or L	ocation										y Limits
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To Be Completed by Funeral Director	11. Marital Status 1 □ Never Marri 3 □ Widowed		arried	2. Was Dec Armed Fo 1 □Yes If Yes, Gi Year or D	rces? 2 [X] N ve		S. 13	. Was Deced If Yes, sped 1 ☐ Yes		ispanic O n, Mexica Specify		ecify Yes or N Rican, etc.)	0-		ce - Amer ck, White ^{y:} Whi	, etc.	ian,	
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	23a. Part 1. Enter the shock, or hea Immediate Cause (disease or conditio	rt failure. Li (Final	or complications	cations that de cause on d	aused	the death		-	de of dyin		s cardiac	-	arres	st,	1	Appro	oximate ral Betv t and D	e veen
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Completed by Physician/Medical Examiner	23b. Was decedent in the past 12 1 □ Yes 2 □	months? ∡No	2		birth nant at	of pregna 2 □ Fetal time of d	death 3	☐ Ectopic p ☐ Other (sp		у					ate of deli onth	very Day	Υ	'ear
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٤.	1 Yes 2 2			28a. Date			ER/Outpation 28b. Time	ent 3 DC	JA	4 Ľ ľ		me 5 Res				cify)		
ation	1 ☑ Natural 2 ☐ Accident	5 ☐ Pend inves	stigation	(Mor	ith, Day	(, Year)	Injury	м	28c. Injun Work 1 □ '	yau (? Yes 2[280. Describe	HOW	rinjury occui	ieu			
ertific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could deter	d not be rmined	28e. Place build	of Inju	ry - At ho . (Specif)	me, farm, s	treet, factory	y, office			28f. Location City or To			ber or Ru	ıral Rout	e Num	ber,
Medical Certification: To	29a. Certifier (Check only one)				asis of	examina						and due to th red at the time					ause(s)
Me	29b. Signature and	title of certif	ier) ol	2	1			c. License					d. Date signe				009
	30. Name and addr	ess of peren	on who co	mpleted cau	se of de	eath (Item	23a) (Tvne	Print)			10			,				-
		VCN	0	1		Jan. (nom	911	Ru	ssel	IA	ve	6zit	hc	rsbur	y M	ld.		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 2 8 2009

(1)a>

32. Fegistřár's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O O

	1 - State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygiene	009 15117
	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
Physician /Medical	Susan Kay Russell		April 24,	2009 ^{Year} 8:52 A M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. C	ounty of Death
and the second	Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	TOWSON If Under 1 Year If Under 24 Hrs.		Ltimore 9. Birthplace (State or Foreign
Funeral Director	233–68–1112 Sex 1 □ M 2 ★ F 7. Age (in yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 8, 1942	West Virginia
	Usual Residence of Decedent		1107 07 1712	
trylan show	10a. State 10b. County 10c. City, Town or Lo	ecation		10d. Inside City Limits 1 □ Yes 2 🛣 No
28a-f	MD Howard Columbia	101 Tie Oede	10g Citize	en of What Country?
with t	10e. Street and Number 6325 Nodding Night Court	10f. Zip Code 21044	USA	of What Country:
fler death with the Marritems 23a or 28a-f shifter cutting the motified.	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spo	ecify Yes or No-	4. Race - American Indian,
	1 Never Married 2 Married 1 Yes 2 Married	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【XNo Specify:		Black, White, etc.
"natural", o	3 ☐ Widowed 4 【XDivorced Year or Dates:			wnite
ed within 72 houygiene. In the Medical Et, the Medical E	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)		d of Business/Industry
r thar	Elementary/Secondary (0-12) College (1-4or 5+) 4 Progr	,	Compi	uter Technology
be filed that Hyge od othe event,	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden S	urname)
should be and Ment s marked umatic e	Virgil Russell	Martha Ed	ith McCallis	ster
2 shc h and 7 Is m traum	1 1 7 7	ng Address <i>(Street and Number or Run</i> Nodding Night Ct.		
1 and 1 Health Health em 27				ation - City or Town, State
Pages nent of int: If it	1 Burial 2 KCremation 3 I Hemoval from State		5/09 Odent	ton, MD
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It = N. once. To Be Comp	21. Signature of Funeral Service Licensee	ong Homes Crematic	n Service	P.O. Box 784
89588				rksville, MD 21029
	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	OF BRUST O	ancel	years
Examiner	Due to (or as a consequence of):			
je je	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.			
executed an and ial-transit Examiner	Cause (Disease or injury that initiated events c			
	resulting in death) Last Due to (or as a consequence of):			
icate be physicia the bui	d			
nat the death certification by the attending petached for use as Physician/Mee	IF FEMALE: 23c. If yes, outcome of pregnancy		23	3d. Date of delivery
death death death d for t	in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
by the a	9 Unknown			
	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.		se contribute to the cause of death?
w requires to the second should be second be second be second be second be second be second by s			1 Yes 2	
The law requirecate has been spage 2 should			24a. Was an autopsy performed2	24b. Were autopsy findings available prior to completion of cause of death?
ician: The l certificate ha ector, page	25. Was case referred to medical	OS Bloom of Dont	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
Attending Physician: r death: ector: After this certific by the funeral director; I	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other:		Sother (Specify) WSO UP
ding Phy h. After thi funeral	27. Manner of D ath 1/D vatural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 1/D vatural 1/D va		28d. Describe how injury	
eath. or: Al the ful	2 Accident investigation	M 1 □Yes 2 □No		
tal or Attending Price of all Director. After led in by the funers led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
	29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause(s)	and manner as stated.
the Hosp ithin 24 hou the Fune ompletely fi	(Check only one) Medical Examiner: On the basis of examination and/or land manner stated.	nvestigation, in my opinion, death occur	red at the time, date and	place, and due to the cause(s)
To the within to the complete Complete Market	29b. Signature and litle of certifier	29c. License number	29d. Date	e signed (Month, Day, Year)
	Maum	150503	APILI	L 27 2009
10/20	30. Name and address of person who completed cause of death (Item 23a) (Type		To ma	01204
State	31. Date filed (Month, Day, Year) 32. gegistrar's Signature	Chaples St.	IONSON, 1010	0 01007
Registrar	APR 28 2009 Sour D. 2	arke		

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Oldio	or mary laria	(Certificat	e of	Death	,	Reg. No O	09	15118
	Physiciar /Medica		1. Decedent's Name (First, Middle, Last)	an					2. Dete of De Month April	Day 25, 2009	Year)	3. Time of Deeth 6:30 am
).	Examine		4e Fecility Neme (If not institution, give street and r Frederick Villa	number)				4b. City, Town, or L Catonsv			y of Deeth Limore	
* <u>#</u>	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 3 ☐ F	7. Age (In yrs. la:	v	day) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 01/19	rth ay, Year)	9. Birthpl Count	ace (State or Foreign ry) Land
A Company	of show	tor	Usuel Residence of Decedent 10a. State 10b. County MD Baltimore			or Location					10	0d. Inside City Limits 1 ☐ Yes 2/2 No
46. 11.124	23a or 28a	Funeral Director	10e. Street end Number 8 Rumford Drive			10f. Zip	Code 2122			10g. Citizen of United	State	s
7		2	Armed	s 2. ∑t No Give	•			dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla	ce - America ack, Whit <i>e</i> , e ify: Whit	etc.
200-01717	Hygiene. Sthor than "naturent, the Madical	Completed	15. Decedent's Education (Specify only highest grade complete) Elementery/Secondary (0-12) College 12	d) (1-4or 5+)	16a. [Decedent's Usu 'Give kind of wo life. DO NOT u Homem	rk done se retire	during most of work d)	ring	16b. Kind of E	Business/Ind Home	ustry
	other vent,	Be	17. Father's Name (First, Middle, Last)	<u></u>				18. Mother's Nam	e (First, Middle	e, Maiden Surna	me)	
1	a marked of	2	Felix Wells						ine Ba			
	Health end Isam 27 is me		19a. Informant's Name/Relationship (Type, Print) John J. Ryan – son	20h Pla	8 :	Folling	ton	and Number or Rus Ct. Halet		-	27	
	permit. Pages I end Depertment of Health important: if itam 27 any injury or other to once.		20a. Method of Disposition 15 Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	m State		Disposition (Na., crematory or C	mori	al 4	1/29/09	Marriot	ttsvil	le. MD
	Depe impo		21. Signature of Funeral Service Licensee Under Quarto	M00845		4112 0	ld C	olumbia E	ike El	licott (ly FH Inc MD 21043 Approximate
	hysician /Medical Examiner	er	23a. Part1. Enter the diseese, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	Vasc	cul	onsequence of)					1	Interval Between Onset and Death
	ding physician and ise es the burial-transit	/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			onsequence of):						
1400	e attendir	clar	Part II. Other significant conditions contributing to	death but not result	tina in	the underlying	cause gi	ven in Part I.	23b. Dic	i tobacco use c	ontribute to	the cause of death
400	igned by the be deteched	by Physician/							1	Yes 2□ No	3 ☐ Prot	pably 45 Unknow
ode sade societados sus of ode	hes been sig	Completed b								s an autopsy formed?	ava	ere autopsy findings ailable prior to mpletion of cause death?
É	ate h									Yes 200	10	Yes 2 No
i	arthis certificate he leral director, page	n: To Be	27. Manner of Death 28a. Da	T	28b. Ti	patient 3 Demo	OA Ot		ome 5□Res	one) sidence 6 🗆0 how injury occu		/)
1	within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At hon Iding, etc. (Specify)	ne, far	М	1 🗆]Yes 2□No		(Street and Num own, State)	nber or Rura	l Route Number,
Linemiant	within 24 hours at To the Funarai I completely filled	edicai C	29a. Certifier (Check only one) Scertifying Physician: To t 2 Medical Examiner: On the	he best of my know basis of examination	ledge, on <i>e</i> nd	death occurred /or investigetion	at the ti	me, date end place opinion, death occu	, and due to the rred at the time	e cause(s) and r e, date and place	manner as s e, and due to	ated. the cause(s)
10.07	within To the compl	Đ X	29b. Signature and title of certifier			29	c. Licen	se number		29d. Date sign	ned (Month,	Day, Year)
) (i)	D-0		Rayman Mulli Mo 30. Name end address of person who completed ca	use of death (Item :	23 <i>e</i>) (1	Type, Print)	DA	76F3		4/2	7/09	
7	700	1)	Rhymeri Millio 25 Main		Sml	T 700		ensusions	MD	21136		
	State Registra	8	31-Date filed (Month, Day, Year) 32 APR 28 2009 2	. Registrer's Signatu	A.	Sark	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Rapp 10:18 A M Mary. L 2009 27 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University of Maryland Medical Center 8. Date of Birth (Month, Day, Yea 2/20/1930 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F 212 - 26 - 2062 MD 79 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tr∝ Missical Examiner must be notified at 1 ☐ Yes 2X No Director Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2826 Pinewick Rd. 21042 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 22€ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Amarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer Roberts Louise Kirby ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2826 Pinewick Rd., Ellicott City, MD 21042
e of Disposition (Name of Date 20c. Location - City or Town, State Leonard Rapp / Husband item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important; If any Injury or once. Crest Lawn Mem. Gdns: May 2, 2009 Marriottsville, MD 4 ☐ Donation S ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. of Funeral M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part I Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 days Physician Bowel ischemia with lactic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Granulosa cell tomer of the OVECY mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last peritoneal Physician/Medical Examiner Due to (or as a consequence of): dissemination Physician; The law requires that the death certificate be executed physician and s the burial-transi Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 🗷 No P.O. 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 🗹 No 1 □ Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 K Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 27, 2009

BYAN Nowak 31. Date filed (Mo.

22 M.D 32. Registrar's Signature

, M.D.

1 Caucah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CREENE

A41476435N18873

SIT BALTIMORE MD

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

niel James R		1- For State	ate of Maryla		ertment of tificate of		Mental H		on No	200	79	1512
Physicia		Registrar 1. Decedent's Name (First, Middle	e,Last)					2. Date of Deat				of Death
dical Exami		Daniel James H	Reed					Month April 25, 2	Day 1009	Year	112	5 hrs
		4a. Facility Name (if not institution		ımber)	4	b. City, Town, or L		th		County of Deat	h	
		Route 261 & Breezy P		7 A (1		Chesapeake	If Under 24Hr	n I O Date of Pic		D/YYYY) 9. Bi	dholace (State or
Funeral Director		5. Social Security Number 215-66-5423	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	Hours Min	_	`	Forei		nington,
		Usual Residence of Decedent	1 X M 2 F	54	Yrs.			January	y 0, 1	1933	ouritry)	DC
any		10a. State 10b. County		10c. City,	Town or Location	on	· · · · ·				10d. Ins	ide City Limits
	'n	Maryland Princ	e George	s Rive	rdale						1 🔲	res 2 X No
Maryla 28a-f	Director	10e. Street and Number				10f. Zip Code		1	0g. Citize	en of What Cou	intry?	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	_	6209 59th Aver	nue			20737			USA			
th wit ems 2 it be n	Funeral	11. Marital Status 1 Never Married 2 X Ma		cedent Ever in U. orces?		s Decedent of Hisp es, specify Cuban,			⊢ 1·	Race - Ame White, etc.	rican India	an, Black,
er dea			1 Yes	2 X No	1	Yes 2 X No	specify:		s	pecify: Whi	ite	
urs aft tural"	d by	15. Decedent's Education (Spec	or Dates:		16a. Decedent	's Usual Occupation	on (Give kind of	work done		nd of Business		
72 hor "na al Ex	ompleted	Elementary/Secondary (0-12)		1-4 or 5+)	during me	ost of working life.	DO NOT use re	etired)				
ooge vithin ene. er tha	ldm		4		Sheet	: Metal M				nstruct	ion	
21215-0036 old be filed within 7 Mental Hygiene. marked other than	ပ	17. Father's Name (First, Middle,	Last)					ne (First, Middle, I	Maiden S	urname)		
212 Ild be Vienta narke	To Be	Paul D. Reed 19a. Informant's Name/Relations	hin (Type Print)		19b. Mailing	Address (Street	Mary Mu		mber. City	or Town, Stat	e. Zip Cod	de)
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	_	Deborah Ann Re		e		59th Ave						
e, Pand I and Health		20a. Method of Disposition		20b.	Place of Disposi crematory or oth	ition (Name of cem	etery,	Date	20c. Lc	ocation - City o	r Town, S	tate
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 Burial 2 X Cremation 4 Donation 5 Other Sp		VIII State		n Cremator	y 4/	30/2009	A1e	xandri	a, V:	irginia
altin mit. partm porta ury o		21 Signature of Funeral Service		0	4 5	ame and Address	•		47:	39 Balt	imor	e Ave.
™ 55 5 5		Ernest	14,0	Lvin		ch's Fun			. Hya	attsvil	Lle,	MD 20781
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			ne mode of dying, s	uch as cardiac	or respiratory arr	rest, shoc	k, or heart		een Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)		neck injur							-	Death
			b.	a consequence o	11).							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence o	of):							
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cuted ind transit		- Common Tooland of the Common Tooland	d									
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	edical	UNPENDED	AMENDED									
76C ficate g phys s the b	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the		outcome of preg		tal death 3	Ectopic pregi	nancy		Date of delive	ery Day	Year
Box 6876(death certificate the attending phy death of the the	()	past 12 months?	LIVE	nant at time of de		tal death 3 L her (Specify)	ctopic pregi	itancy		nona	Day	7 001
Bo e deat the att	Physic		known 9 Unkn									
ision of Vital Records, P.O. Box 6876i Attending Physician: The law requires that the death certificate death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the b	by P	Part II. Other significant condit	ions contributing t	to death but not r	esulting in the u	inderlying cause gi	ven in Part I.			se contribute t		
IS, F quires en sign								24a. Was				ndings available
cords, law requir	ompleted							auto			completion	on of cause of
Vital Records, ysician: The law require his certificate has been sidirector, page 2 should be	Con							1 🗸 Yes				2 No
ital ician: s certi	Be	25. Was case referred to medica examiner?	Hospital:	In-stient 0	ER/Outpatient		of Death (Chec Other: Nurs	k only one) sing Home 5	Posidon	nce 6 🗸 Oth	or: Scana	-
n of Vital ding Physician: . After this certi	٠ <u>.</u>	1 ✓ Yes 2 No 27. Manner of Death	الا	Inpatient 2	28b. Time of I		y at Work?	28d. Describe			- 30010	
ion c tending eath. tor: Af the fun	tion	1 Natural 5 Pend	A no (Mont	h Day Year) 2009	1116 hrs	1_ Y	es 2 🗸 No	Motorcyclis	st colli	ided with	van	
Division tal or Attendir rs after death. al Director: A	ertification:		stigation 28e. Pla	ce of Injury - At h	ome, farm, stree	et, factory, office bu	uilding, etc.			id Number or F	Rural Rout	e Number, City
Divisor / Diviso	erti	- Guicide Godi		Major Roa	ıd / Highway			or Town, Route 261 &	State) Breezy I	Point Rd, Ch	esapeak	e Beach, MD
Divi To the Hospital or within 24 hours afte To the Funeral Dir	cal C		hysician: To the be miner:On the basis									(s)
To the within To the Comp	Medical	29b. Signature and title of certifie	and manner			29c. License				ate signed (M		
4	_	11 - 7	D. I Marl	ŝ		O.C.N				26, 2009	,)	
A.		30. Name and address of person	Who completed car	ise of death (Iten	n 23a)							
191		Margarita Korell MD.	Assistant Me			enn Street, Ba	altimore, MD	21201				
	tate	31. Date filed (Month, Day, Year)	32. F	egistrar's Signat	ure	-						
Regis	trar	AFR & B ZUUS	Beneva	1. 60	old	· · · · · · · · · · · · · · · · · · ·						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 23 Pay 2009 **Physician** Рм 4:11 Richard L Rhoderick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 8. Date of Birth (Month, Day, Year) 924 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 215-28-5377 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 21703 USA 7401 Willow Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1944.
If Yes, Give
Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** X o Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. "Important: If Item 27 is marked other than "natu any injury or other traumatic event than" natuen. 15. Decedent's Education (Specify only highest grade completed) federal College (1-4or 5+) Elementary/Secondary (0-12) gov't <u>civil engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Bowlus George Carlton Rhoderick Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090419a. Informant's Name/Relationship (Type. Print) 204 Colesville Manor Dr., Silver Spring, MD John C. Rhoderick (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Buria Cremation 3 Removal from State Lutheran cemetery 4/28/09 Middletown, MD 4 Dopation 5 ☐ Other (Specify) 21. Sign Jure of Donald B. Thompson Funeral Home 18, Middletown, MD 21769 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) The law requires that the death certificate be executed Exam attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an has certificate 1 □Yes 2 No Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pleating 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43780 4/24/09

State Registrar

DHMH 17 Rev 1/2001

8+1

Kevin E. Hohl MD

31. Date filed (Month

Brilleton MD 21769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 20 300 S. church St.

CABCANE.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	orato or mar	(Certificate of	Death	,	Reg. No.	2009	15126
	Physicia	en.	1. Decedent's Name (First, Middle, Las					2. Date of De Month April		2009 ^{Year}	3. Time of Death
	/Medic		Wanda C. Ri		-	Ab City Town o	r Location of Death			County of Death	2:40 P M
ا الر	Examin	er	4a. Facility Name (If not institution, give Kline Hospice			Mt. A			40,		lerick
	Funeral Director		5. Social Security Number 6. Social Security Number 1. Social Security	7. Age	In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D May 3	rth lay, Year) • 196	9. Birtt Cod Ma	hplace (State or Foreign untry) uryland
	and		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town of	or Location					10d. Inside City Limits
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	or 28a)irec	10e. Street and Number			10f. Zip Code				tizen of What Co	-
	ath wi	Funeral Director	109 West B. Stree		T	2171				ited Sta	
	ter de	Fune	11. Marital Status 1 ☐ Never Married 2X Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 🕅 No	er in U.S.	13. Was Decedent of H If Yes, specify Cuba		o Rican, etc.)	0-	14. Race - Ame Black, White	
036	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Evaninar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:			Specify: Wh	nite
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פַ	al Hygi other	Be C	17. Father's Name (First, Middle, Last)	-			18. Mother's Nam			•	
ylar	2 should be to and Mental Is marked o raumatic eve	2	George Funk			,		Janice			
altimore, Maryland 2121	ies 1 and 2 should b t of Health and Ment If item 27 Is marked or other traumatic e		19a. Informant's Name/Relationship (Raymond Rife / Hu		19b. l 320	Mailing Address (Street) West Poto	mac, Apai	ral Route Num	Bru	nswick,	MD 21716
ore	Pages 1 and the second of the		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	cemetery,	Disposition (Name of crematory or other place		Date		ocation - City or	
<u>=</u>			4 □ Donation 5 □ Other (Specify	<i>(</i>)	Stauffe	er Cremator 22. Name and Addre		5/2009		_	, Maryland
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused the	ne death. Do no					ISWICK,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	HYPO							Onset and Death MINUTES
-50	/Medical Examiner		resulting in death)	Due to or as a							DAYS
		er	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	UMONIA consequence of	9:					
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Sign	w requires that s been signed t should be deta					·		1 🗆	Yes 2	2 □ No 3 □ P	robably 4 Unknown
Division of Vital Records,	sician: The law r certificate has be irector, page 2 sh	Completed							opsy formed?	prior to death?	utopsy findings available completion of cause of s 2 No
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<u>Š</u>	al or Att s after de il Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.		n, street, factory, office		28f. Location City or T	(Street a own, Stat	nd Number or R e)	lural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Medical C		nysician: To the best of niner: On the basis of and manner state	examination and						
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number			ate signed (Mon	
			the state of				06196		L	04-23	
KE	5		30. Name and address of person who SADAF TAIMUL	completed cause of dea	ath (Item 23a) (1 - B THT	Type, Print) MAS JOH	MSON DK	PRE	DER	zick n	10 21702
¥	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 20	32 Registrar	's Signature	parker					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17^{Day}2009^{Year} April 1845 Gloria E. Standsbury 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🔀 F 14 1927 Maryland <u> 215-32-0168</u> 81 June Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 TYes 2 No Prince George's Temple Hills Maryland 10e. Street and Number 10g. Citizen of What Country? 3205 31st Avenue USA 20748 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ∐Yes 2 X No Black Specify: Specify: 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Private Family O Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John R. Thomas Jr. Clara Spriggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 31st Ave. Temple Hills, Md. 20748 Gloria Nick (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Broadneck 4/25/09 St. Margarets, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons MOrtuary, West St. Annapolis, Md. Larry B. Beese Mo 483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BACTEREMIA Due to (or as a consequence of): FAILUNE Sequentially list conditions and the state of t ANEMIA Due to (or as a consequence of): OROWARY DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an IAGETES MELLITUS 2 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 XNatural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

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Examine Physician/Medical þ Completed certificate Be Certification: To : After thi funeral o

Physician

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

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Division

Medical

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Registrar

SISOM 05(A 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

9628

MARLBORD PIKE, 2. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D48158

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) APRIL 17, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 20772 UPPER MARLBORD

6 ☐ Could not be

Ward Jones Dry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 0.00

			State of Maryland / Department 1 - State	ent of Health and ate of Death	d Mental Hygier Reg. N	C 0 0 0	15124
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	F1			der 1 Year If Under 24 h	rs. 8. Date of Birth	9. Birthi	place (State or Foreign
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<u>≅</u>	r Att	Certification: T	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ctory, office	28f. Location (Stree City or Town, S	tate)	a Harwood,
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	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 4 2009				

DHMH 17 Rev 1/2001

Funeral Director

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	1 - State Registrar	ate of Marylani		rtificate of			Reg. No.	UY	15125
n al	1. Decedent's Name (First, Middle, Last) Wurch Stedman	,				2. Date of De Month	Day	Year 2000	3. Time of Death
r	4a. Facility Name (If not institution, give street University of Masyland Medical			4b. City, Town, or Biltimore,	Location of Death		4c. Coun	ty of Deat	h
	5. Social Security Number 6. Sex 150 M	7. Age (In yrs. I	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year) (423	l Co	hplace <i>(State</i> or Foreign untry) IASS •
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a Dir	10e. Street and Number 22824 Laurel Haven V	lay		10f. Zip Code	20653			USA	ontu y :
Be Completed by Funeral Director	1 ☐ Never Married 2 🖾 Married	Nas Decedent Ever in U.S Armed Forces? Mayes 2 □ No 194 fYes, Give Year or Dates: 194	3-	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛛 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Decify Yes or No Decify Yes	14. Ra Bl	ack, White	rican Indian, e, etc. Vhite
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S	17. Father's Name (First, Middle, Last)	4	Sale	esman	18. Mother's Nam	ne (First. Middle	Plas		
lo Be	George W. Stedman				Nellie (,		
-	19a. Informant's Name/Relationship (Type. I	Print)	19b. Mailii	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Tow	n, State, 2	Zip Code)
	Florence Stedman S	Spouse		Laurel H		Lexing	gton Par		
	1X Burial 2 ☐ Cremation 3 ☐ Remo	oval from State		osition (Name of matory or other place Veterans	ce)		Crowns		
	21. Signature of Funeral Service Licensee		1	2. Name and Addre		ardesty nnapolis			ne, P.A.
	23a. Part 1. Enter the disease or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	Preumon	i. Do not en						Approximate Interval Between Onset and Death
_		Due to (or as a consequ							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequ	ience or).						
	resulting in death) Last	Due to (or as a consequ	uence of):						
Be Completed by Physician/Medical	in the past 12 months?	If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3	☐ Ectopic pregnand ☐ Other (specify) _	Ży			Date of de Month	livery Day Year
ed by Pr	Part II. Other significant conditions contributions		•	underlying cause giv			tobacco use co Yes 2 ☑ No		o the cause of death? robably 4 ☐ Unknown
Sompleto		'				24a. Was auto perfe 1 □Yes	an 24l psy ormed? 2 V/No	o. Were an prior to death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical examiner?	ital		oth of the second	26. Place of Dea				
): To	ILI tes Zigino	1 ☑ Inpatient 2 ☐ 8a. Date of Injury (Month, Day, Year)	28b. Time o	of 28c. Inju	4 □ Nursing H	lome 5 ☐ Res 28d. Describe	idence 6 C		ecify)
Medical Certification: To	2 Accident investigation	_	Injury	M 1	k? Yes 2 □ No	20f Location	(Chunga and New	mber or P	ural Route Number,
Certif	4 Homicide determined	8e. Place of Injury - At ho building, etc. (Specif	y) 			City or To	wn, State)		
dical	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	an: To the best of my kno On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the to nvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and , date and plac	manner a e, and du	s stated. e to the cause(s)
Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sig	ned (Mon	th, Day, Year)
7	Mr for			(, ,	544741		April	19(17)	loos
	30. Name and address of person who complete Adam Branet, 22	eted cause of death (Item	123a) (Type,	, Print) Baltmore, A	10 21201				
e	31. Date filed (Month, Day, Year) APR 23 200	South Greene 32. Registrar's Signa	ture d.	bare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 19, 2009 Year \mathbf{a}^{M} 7:50 April Sepulveda Dorina 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery 01ney Montgomery General Hospital 8. Date of Birth (Month, Day, Year) Jan. 20, 1925 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Chile Social Security Number Months 1 □ M 2 🖾 F Yrs. 84 577-84-2864 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 ☐ Yes 2 X No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Chile 20906 13805 Rippling Brook Drive 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 XYes 2 No Specify: Chilean 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orellana Maria Fuentes Leoncio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12224 Berry Street, Silver Spring, MD 20902 Mario Sepulveda / Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Brentwood, MD Ft. Lincoln Crematory 04/28/2009 4 □ Donation 5 □ Other (Specify) Simple Tribtue 22. Name and Address of Facility 21. Signature of Funeral Septice Licensee 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. LXAD Immediate Cause (Final HEART FAILURE CONGESTIVE disease or condition resulting in death) Due to (or as a consequence of): INFARCTION MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death IF FEMALE: Year 23b. Was decedent pregnant Month 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f sl event, tre Medical Examirer coast be notified

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nr any injury or other traumatic event, I're Medic once.

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examine Physician: The law requires that the death certificate be executed physician and strans

Physician/Medical

2

Completed

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Certification: To

Medical

use as attending

cate has been signed by the page 2 should be detached

within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page

or Attending

Hospital

To the within 2

resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed 2 11No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

(Check only one)

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

Rboch

H0065661

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stein

Montgomery General Hospital Olney

MO 20832

State Registrar

31. Date filed (Month; Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4:32M 2009 SUSAN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore **Baltimore City** The Johns Hopkins Hospital Birthplace (State Country) MD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) State or Foreign 6. Sex 5. Social Security Number April Day Year) 1961 Months 1 □ M 2 🕱 F 48 212-88-2108 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🛣 No LaPlata MD Charles 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number **IISA** 8352 James Carroll Pl. 20646 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2x
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married 2 No Specify: White 1 ☐ Yes 2x No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Charles County Gov. EMS Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Spalding Charles F. Spalding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 261 LaPlata, Md. 20646 Irene Spalding/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/09 LaPlata, Md. Sacred Heart Cem. 21. Signature of Funeral Service Licenses AREHART-ECHOLS FUNERAL HOME, PA M00945 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Box 567 LaPlata, Md. 20646 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque ce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Year Month in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? la. Was an autopsy performed: 2 □ No Yes 2 No 1 🗌 Yes k onl one) ☐ Residence 6 ☐ Other (Specify)

Physician /Medical **Examiner** or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

g physician and as the burial-trans the funeral director, page 2 should be this within 24 hours after death.

To the Funeral Director: After

Examiner Physician/Medical Completed by Be ၉ Certification: filled in by Medical

_					1 □ Yes 2	No 3 ☐ Probably 4 ☐ Unkr			
-					24a. Was an autopsy performed? 1 Yes 2 □ No	24b. Were autopsy findings avait prior to completion of caus death? 1 ☐ Yes 2 ☐ No			
25.	. Was case referred to medical			26. Place of Death	Check onl one)				
	examiner? 1 ☐ Yes 2. No	Hospital: Inpatient 2 ER/Ou	utpatient 3 DOA	Other: 4 Nursing Ho	me 5 Residence 6	5 Residence 6 Other (Specify)			
27	7. Manner of Death 11 Natural 5 ☐ Pending 2 ☐ Accident investigation			c. Injury at Work? 1 _ Yes 2 _ No	28d. Describe how injury occurred				
	3 Suicide 6 Could not b	e 28e. Place of injury - At home, fa	arm, street, factory, o	office	28f. Location (Street and	d Number or Rural Route Number			

escribe how injury occurred

April, 22, 2009

	4 Homicide	determined	building, etc. (Specify)	et, lactory, office	Cify or To	own, State)
	29a. Certifier (check only one)	1 Certifying Physi 2 Medical Examin	cian: To the best of my knowledge, death er: On the basis of examination and/or in and manner stated.	occurred at the time, date and place restigation, in my opinion, death occ	ce, and due to the curred at the time	ne cause(s) and manner as stated. ne, date and place, and due to the cause(s
ı	40			20 11		and Data signed (Month Day Year)

RES 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIIS

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)



2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 27, Day 2009 Year **Physician** 9:52 Shank AM Wayne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Williamsport Washington 10617 Greenwich Dr. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** M 2 F Months Days Hours July 15, 1941 Maryland **Director** 220-40-0644 67 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Directo Maryland Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 U.S.A. 10617 Greenwich Dr. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufacturing Engine Assembler 12 should be filed w h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental th Important: If Item 27 is marked oth any Injury or other traumatic event once. Be Miller Shank Rosalyn Daugherty ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10617 Greenwich Dr. Williamsport Maryland 21795 Joann Shank Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2009 Hagerstown, Maryland 4 Donation 5 ☐ Other (Specify) Rest Haven Cemetery 21. Signature of Funeral & rvie Densee 22. Name and Address of Facility Rest Haven Funeral Chapel .1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death 16001 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last This to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. Expense the this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 No 3 Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yg/s 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State Registrar

SHOT

30. Name an

31. Date filed (Month, Day, Year)

MD 11110 Medical Campus Rd. 32. Registrar's Signature

Hurwin

APR 30

eted cause of death (Item 23a) (Type, Print)

21742

Hagerstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Fleath and State Registrar For State of Maryland / Department of Fleath and Certificate of Death		Reg. No.	15129
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year	3. Time of Death
	/Medic		John Albert Scibilia	April	28 2009 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea			shington
	Funeral		1.0611 Oak Tree Circle Williamsport 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr.	s. 8. Date of Bir	th 9. Bi	rthplace (State or Foreign country)
	Director		130-20-2350 **Am 2 F 80 Yrs. Months Days Hours Min	Dec.11	,1928 Ne	w Jersey
	death with the Maryland ims 23a or 28a-f show r must be rotified at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2\\ X\ No
	the M 28a-f	Director	Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	with 1	<u>D</u>	10611 Oak Tree Circle 21795		0	ISA
	ms 2:	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No	14. Race - Am Black, Whi	
5-0036	be filed within 72 hours after death with the Marylan tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the "Medical Evandaria" in 1st to rollified at	by	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? MXYes 2 No 1951- If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	no moan, etc.)	Specify:	White
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	2 should be and Mental is marked or raumatic ever	၉	Albert Scibilia Carrie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or F			Zin Cada)
a Z	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Type. Print) Mary Louise Scibilia-Wife 19b. Mailing Address (Street and Number or F			yland 21795
	ges 1 and 2 should nt of Heatth and Mer I ff item 27 is marke or other traumatic	L S	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	
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O. Box 6	ath cer attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 0 Unknown 0 Unknown 2 No 1 Unknown 2 Unkno		23d. Date of o	delivery Day Year
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	hysic his ce I direc	10 E			sidence 6 Other (S	pecify)
Ĕ	iding Physician: th. After this certification of the director, is	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe	how injury occurred	
Division of	r Attending Physician: er death. rector: After this certific by the funeral director, I	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
Ξ	ital or Ins aft ral Di			1	. (1) 1	- an atatod
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) **Description of the best of my knowledge, death occurred at the time, date and place and place one) **Description of the best of my knowledge, death occurred at the time, date and place and place one one) **Description of the best of my knowledge, death occurred at the time, date and place and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place one of the best of my knowledge, death occurred at the time, date and place of the best of the best of my knowledge, death occurred at the time, date and place of the best of the best of my knowledge, death occurred at the time, date and place of the best of my knowledge, death occurred at the time, date and place of the best of my knowledge, death occurred at the time, date and place of the best of the best of my knowledge, death occurred at the time, date and place of the best of th	courred at the time	e, date and place, and c	due to the cause(s)
	To the complete compl	×	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
			1 Pepsah MD 005818	1	AHRIL 28	, 2009.
ر ا	H 7+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOSUAH PEPRAH 324 E. Antietam St. # 30	6 HAGE	ERSTONN N	nD 21740
	Sta Registi		31. Date filed (Month, Day, Year) 32. Rygistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 2009 Year April 25, **Physician** 7:30 A M Daniel Joseph Shea /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Woodsboro Frederick 10750 Coppermine Road 8. Date of Birth (Month, Day, Jan 19, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 1 XI M 2 □ F 1937 578-46-6894 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Frederick Woodsboro 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21798 items 23a 10750 Coppermine Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. (unk) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 □Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 X Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Shea Anne Marie Monica 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Page: 1 and 2 s
Department of Health a
Important: If tem 27 is
any Injury or other tra. 10750 Coppermine Road Woodsboro, MD 21798 Jennifer Shea/daughter Saltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Page 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory | 04/28/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 10 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** year a End Stage Skin Cancer Metastatic to Liver disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner week Jaundice Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Yinknown nis certificate has been s director, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer 1 □Yes 2 □XNo 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Plospital or Attending Pl 24 hours after death. Funeral Director; After the After t 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 27, 2009 D54749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen Reilly, M.D. 801 Tollhouse Avenue #D1 Frederick, MD 21701 31. Date filed (Month, Day Year) Registrar's Signature State 2009 parke Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death **Physician** Delores Savage 200 Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days 1 M 2 X 578-64-9785 Director Apr 20 1947 Wash, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any liutry or other traumatic event, the Medical Evaninar must be notified at once. tyEyes 2 No Director MD Prince George's New Carrollton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8501 Nicholson Street 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 22 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Tax Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McDaniel Savage Mildred Munsell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Nelson/daughter 8501 Nicholson Street, New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Apr 30 2009 Clinton, MD 4 ☐ Donation ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home S natura of Fundral Service Licenses 7474 Landover Road, Landover, MD 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Chronic obstructive pulmone unknown /Medical Due to (or as a consequence of): Examiner orgaliv. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No After this certificate has funeral director, page 2: autopsy performe 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 🗌 No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled

Division of Vital Records, P.O. Box 68760,

State

2

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARAHIFAR M.O

32. Registrar's Signature

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D43446

29d. Date signed (Month, Day, Year)

4.25.09

Georgia Avesuit 3-32 Silverspring MD 20902

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL **Physician** VIRGINIA MAE SCOTT-DAVIS 2009 1:53 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1407 W. OLD PHILADELPHIA ROAD CHARLESTOWN CECIL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, AUG 30, 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 1 □ M 2 💢 F 218-32-7721 74 1934 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show the Medical Examiner must be notified Director 1 Yes 2 No CHARLESTOWN MARYLAND CECTL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 1407 W. OLD PHILADELPHIA ROAD 21914 UNITED STATES Funeral items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 0 1 ☐Yes 2 ☐No Specify: 3 Specify: BLACK 3 ₩ Widowed 4 □ Divorced "natural" Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nt of Health and Mental Hygiene.

If Item 27 is marked other than or other traumatic event. Item M. Elementary/Secondary (0-12) College (1-4or 5+) FISCAL ACCOUNTS SUPERVISOR FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be JOHN S. SCOTT, SR. BENNIE TISHER DUPREE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LISA SCOTT-COLEMAN / NIECE 500 PINEY POINT DRIVE, PERRYVILLE, MARYLAND 21903 Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JAMES UNITED CEM. 04/28/09 HAVRE DE GRACE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 Siz Sett · Coloman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malnutriton /Medical Due to (or as a consequence of): Examiner Scheroderm Sequentially list conditions Examiner Due to jor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year Pregnant at time of death 5 Other (specify) I ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Kymoner 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2; autopsy certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 15632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ydney Π West High St Ste 312 Elyon MW 100 w 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 27 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Samoson Elaine ON 2009 Patricia /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4 County of D County of Death **Examiner** rince Hespita reverb George ge (In yrs. last birthday) 6 2 Yrs. If Under 1 Year Social Security Number 8. Date of Birth **Funeral** Min 1 □ M 2 M F Director 07 -02-Vicsima Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29809 23a Funeral death 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Martin and Once. 1 Never Married 2 Married ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐Yes 2 No 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1705taura 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) hoad 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Harrisonburg, VA 22802 00 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗆 Burial Cremation 3 Removal from State Harrisonburg, VA Harrisonburg Cremation Service -16· 7009 4 Don Other (Specify) 21. Signi 22. Name and Address of Facility uneral Service License Harrisonburg, VA tureral Approximate Interval Between Onsetand Death 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bck, or heart failure. List only one cause on each line. shock, or heart failu Imme late Cause (Final disease or condition resulting in death) Onset and Deat **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Obstructive vears Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sepsis 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ္ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 016273

State Registrar

DHMH 17 Rev 1/2001

istrar MAY 11 20

Name and address of

31. Date filed (Month, Day, Year)

32. Registrar's Signature

(Item 23a) (Type, Print)

ORIGINAL

. Chevery, MD

20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0428 2009 30 April Larry G. Simpson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** i**X**M 2□ F Months Days Hours March 19,1964 Keyser, Director 233-11-8456 45 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director Mineral New Creek 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò items 23a Funeral HC 75, Box 67-A 26743 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 X No Specify Specify: à 3 Widowed 4 X Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Learning Center Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any Injury or other traumatic event, Ing. M. once. 12 Custodian Developmental Workshop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Robert Rawlings Thelma Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Macil Davis Haines/Friend HC 75, Box 67-A New Creek, WV 26743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 5 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Antioch, WV Thrush Cemetery 22. Name and Address of Facility Smith Funeral Home Brian 85 S. Main Street Keyser, WV 26726 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Rhabdomylosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3days injur Sequentially list conditions, dun, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred severe back strain lifting table 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗖 No 4-24-09 unknown n 24 hours after death

te Funeral Director: / 2 Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Newcreek, w. Va HC75 BOXLOTA nome Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

within 2

29c. License number

D0066101

29d. Date signed (Month, Day, Year)

GOO SETON DR CUMBERLANDING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Kenneth 2009 NY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Avenue gewat 1 If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) 12/21/1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Min Days 1 € M 2 🗆 F Maryland 218-26-8952 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinating the natified on once. Edgewater 1 ☐ Yes 2021 No MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21037 USA 210 Linden Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married 🏋 Married altimore, Maryland 21215-0036 White 1 ∐Yes 2XXXIo Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter/Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Irelend James Taylor ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3726 Muddy Creek Rd. Edgewater, MD 21037 Dana Taylor Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Church Cemetery 4/24/2009 West River, MD 20779 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

William P. Joves, m.D.
31. Date filed (Month, Day, Year)
32. Registrar's Signature

30. Name and address of person who completed a use of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dav Yeer **Physician** APRIL 2009 GEORGE STEPHEN THOMPSON 25**,** 0146 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3000 NORTH DECLARATION CT. CHARLES WALDORF If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 X M 2 □ F 1953 WASHINGTON, D.C **Director** 56 MARCH 16, 217-60-8380 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Examinat must be notified at 1 X Yes 2 □ No Director MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3000 NORTH DECLARATION CT. 20603 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify. BLACK Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED TRANSPORTATION 12 should be filed w h and Mental Hygiei 7 is marked other tt 10TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17 Father's Name (First, Middle, Last) Be ROY ADRIAN THOMPSON FRANCES IRENE SAVOY THOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BRISCOE / FIANCEE 3000 NORTH DECLARATION CT. J. WALDORF, MARYLAND 20603 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. PETER'S CHURCH CEM. 4/30/2009 WALDORF, MARYLAND 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN 21. Signature of Franeral Service Libensee LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) physician Physician/Medical the as. attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Day in the past 12 months? Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 X No certificate 1 ☐ Yes 2 ☐ No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide completely filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical and manner stated To the I within 2.

State

72 hours after

Maryland 21215-0036

Baltimore,

executed

certificate be

Box 68760,

P.O.

Division of Vital Records,

Attending Physician:

31. Date filed (Month, Day, Year) APR 27 2009

NALIN MATHUR, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

11855 HOLLY LANE #107 32. Registrar's Signature

Registrar

29c. License number

D52289

HOLLY BUILDING

29d. Date signed (Month, Day, Year)

20601

April 27, 2009

WALDORF, MD

Physician Division of Vital Records, P.O. Box 68760,

Examiner anding physician and use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed been signed by the attenshould be detached for u After this certification funeral director, p within 24 hours atter death.

To the Funeral Director: A completely tilled in by the fu

Physician

/Medical

Examiner

Funeral

Director

Items 23e or 28a-f show

"naturel", or

permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel, any injury or other treumatic event, Ite Medical Ex. 2016.

/Medical

Funeral Director

Completed by

Be

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10:55 AW

Baltimore, Maryland 21215-0036

JOHN TEREYLA

	1 ☐ Burial 2 ⚠ cremation 3 ☐	Removal from State	cemetery, crema	tory or other place)			,				
'4 Donation 5 Other (Specify) Smithsburg Crematory May 1,2009 Smithsburg, Marylan											
21. Semature it Funeral Bervice Livins - OSDVarie Address of Fallity Home, P.A.											
1	V VAITTE CA	u_	425	S. Conocc	cheague	St. Willi	amsport	, MD 21795			
	23a. Part L Enter the disease, or com- shock, or heart failure. List only	plications that caused to	he death. Do not enter	the mode of dying, su	ch as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death			
	Immediate Cause (Final										
	disease or condition resulting in death)										
		years									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sequentially list conditions, any, leading to immediate Due to (or as a consequence of):									
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	resulting in death) Last	Due to (or as a									
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Due to (or as a consequence of): ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or a											
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1	use contribute t	the cause of death?									
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						autopsy performed?	prior to death?	completion of cause of			
					Di (Dth (1 Yes 2 No	1 L Yes	2 □ No			
	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death (C COther (Co.				
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	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work?	2 🗆 No	,					
	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, stree . (Specify)	t, factory, office	28	If. Location (Street ai City or Town, State	nd Number or R e)	ural Route Number,			
	29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of and manner state	f my knowledge, death of examination and/or invested.	occurred at the time, ostigation, in my opinio	late and place, an on, death occurred	d due to the cause(s d at the time, date an) and manner a d place, and du	s stated. e to the cause(s)			
	29b. Signature and title of certifier			29c. License nu	mber	29d. Da	te signed (Mon	th, Day, Year)			
	> AW So	7		D 21	516	Ar	RIL	272009			
	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pi	rint)	AU E	TREDER	vik 11	N 21702			

DHMH 17 Rev 1/2001

State Registrar

03H1

32. Ragistrar's Signature

09-03561 Walter Tile Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 | 5|39

alter 11	ISON		- For State	State of I	viai yiai iu /	Certi	ficate o	of Death				j. N o.			
F	hysicia		egistrar . Decedent's Name (First,	Middle,Last)							2. Date of Death Month May 3, 200		ear	3. Time of Death 1102 hrs	
	Exami	ner	Walter		Allen			Tilson 4b. City, Tow	n or Loca	tion of Death	May 3, 200	4c. County	of Death		
				a. Facility Name (if not institution, give street and number) Western MD Health System Braddock Campus					land	(IOII OI DOGGI		Allegany			
_			5. Social Security Number	6. Sex		(In yrs. last	birthday)	If Under 1		Under 24Hrs.	8. Date of Birt	n(MM/DD/YY)	Y) g. Birt	thplace (State or on Vingini	а
	uneral irector		229-49-2517	1 X M		0		rs. Months	Days F	lours Min.	07/29/			untry)	
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415	23a or 28a-f show notified at once.		213 N.	Lee Str						502	if	14 Pa	USA	rican Indian, Black	k.
Z i	n willing	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexica							exican, Puerto	Rican, etc.)		nite, etc.		
	or ite		3 Widowed 4	Divorced If Y		No	1	Yes 2 X	No sp	ecify:		Specif	y:	White	
d	urs aut ural" unine	<u>\$</u>	15. Decedent's Education			pleted)	16a. Dece	dent's Usual Oo most of worki	ccupation	(Give kind of	work done	16b. Kind of	Business	/Industry	
	/2 hou	etec	Elementary/Secondary		College (1-4 or 5		auring	Labore		71407 430 100	,	F	Roofi	ทg	
5-0036	led within 72 Hygiene. other than *	ompleted	12					Labore		Mother's Name	e (First, Middle,	1			
15.	filed v I Hygi ed oth t, the	ပိ	17. Father's Name (First, Arthur		Lewis		Tils		K	arin	Anne		Rot	ruck	
2121	and 2 should be filed within 72 hours alter deam with the baays and teelth and Mental Hygiene. The leep 15 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner.	To Be	19a. Informant's Name/Re								Rural Route Nu				
Q.	2 sho th and 27 is umatic	-	Karin A. Ti		Mother			oute 4			idgeley Date	, WV Z	20753 on - City (or Town, State	
e,	f Healt FHealt Fitem		20a. Method of Disposition 1 X Burial 2 Cr	emation 3	Removal from St	ate c	rematory o	r other place)		i					
e E	Pages nent o ant: 1 or oth		4 Donation 5 C	ther Specify:		Da	vis M	emorial	L Cem	. 05/	07/2009	Cumbe	<u>erlar</u>	nd, MD L Home,	P . A .
Baltimore,	permit. Pages I and 2 should be filed within 12 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical		21. Signature of Funeral	Service Licenses	· /						t, Cumb			21502	
	ysician		23à Part I. Enter the disc	ease, or complica	ations that caused	the death.	Do not en	ter the mode of	f dying, su	ch as cardiac	or respiratory ar	rest, shock, o	heart	Approximate Between Or	nset and
	edical	ŀ	failure. List only on- Immediate Cause (Final	e cause on each	theroscl	eroti	c car	diovas	cular	disea	se			Deal	th
	.aminer	l	or condition resulting in		e to (or as a cons										
		-	Sequentially list condition if any, leading to immediate	ns, b ate Du	ue to (or as a cons	sequence o	f):								
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	rres that the death certificate be executed signed by the attending physician and he denached for use as the burial - transit	Medical	XUNPENDED		AMENDED 23	a,PII	,27,	perME,	g891	5/22/0)9 TT		_		
,09	ate be physical he buri	Med	IF FEMALE:	and in the	23c. If yes, outco	ome of preg			3	Ectopic preg	nancy		ite of deliv		Year
Box 687	certific nding 1 se as tl	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)												
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Ö	at the	A		nt conditions	contributing to dea	ath but not r	esulting in	the underlying	g cause giv	en in Part I.				Probably 4	
<u>م</u>	ires the signed) d	Obesity						_		24a. Wa	as an	24b. Were	e autopsy findings	s available
òrd	certificate has been	ompleted									pe	topsy rformed?	death		No No
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<u></u>	certifi	Be C			ospital:	tient 2 🗸	FR/Outn				rsing Home 5	Residence	6 C	Other:	
Division of Vital Records, P.O.	ing Physic	[F	1 Yes 2	No	28a. Date of It	-				at Work?		e how injury	occurred		
2	nding th.		1 X Natural 5	Pending		y,Year)			1 Y	es 2 No					
	r Atter	i i	2 Accident 3 Suicide 6	Investigatio	28e Place of	Injury - At	home, farm	n, street, factor	y, office bu	ilding, etc.	28f. Locatio or Tow	n (Street and n, State)	Number o	or Rural Route Nu	imber, City
. <u>.</u>	Hospital or Attend 24 hours after death Funeral Director:	Cortification.	4 Homicide	determined	(Specify)							()		atatod	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and the formal properties of the prop	etery 1		tifying Physicia	on: To the best of	my knowle	dge, death	occurred at th	e time, dat ny opinion.	te and place, death occurr	and due to the o ed at the time, d	ause(s) and mate and place,	anner as and due	to the cause(s)	
	To the within 2	Complete	one) 2 Me		and manner state	ed.	31.0701 1119		c. License			29d. Dat	e signed	(Month, Day, Yea	ar)
		2	29b. Signature and title	of certifier .	m.D			-	O.C.N			May 4	, 2009		
			30. Name and address			of death (Ite	em 23a)								
			Ling Li, MD	Assistant M	edical Exami	ner 11	1 Penn	Street, Balt	timore, I	MD 21201					
		Sta		Day, Year)	1 4	rar's Signa	ature	1	1.1						
	Pos	istr		I I YAN	2009 /	men.	, B.	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician Mauna Kathleen Vogan 19 2009 P^{M} April 8:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Casey House Montgomery Hospice Rockville Montgomery 8. Date of Birth (Month, Day, May 18, Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Illinois 1912 341-32-1321 96 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1XX Yes 2 ☐ No Director MD Prince Georges New Carrollton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 6123 85th Place items 23a 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 ò, 1 ☐ Yes 2 K No If Yes, Give Year or Dates: WWII Specify: Completed by 3 ₩idowed 4 Divorced natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental fis marked ot မ Samuel R. Hainline Grace I. Cunningham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mauna V. Kammer Daughter 15 Tynewick Court, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. June 22, 09 Arlington, Va 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature/of Funeral Service Ligense Willia 5130 Wisconsin Ave. N.W. Washington D.C. 20016 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed -transit Colon Cancer Due to (or as a consequence of): g physician and the purial-t Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 1∐ Yes 2 📆 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death within 24 hours after death to the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٩ Jewlyne Kouatchou, MD 00063742 April 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mills Rd, Rockville, Md 20855

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 22,2009 12:55 PM Agnes R. Valleau /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Salisbury Rehabilitation + Nursing Ctn Wicomico Salisbury If Under 1 Year | If Under 24 H/s. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1 □ M 2 🕱 F Months 11/9/1916 Director 92 055-10-1596 New York Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked cither than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 1X Yes 2 □ No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 W. Main St. 21801 Funeral Suite A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Completed by Specify Specify: White 3 Midowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Secretary Instrument Co. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Edward Murphy Anna Culkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 Upland Dr. Salisbury, Maryland 21801 Bernard Murphy/brother-in-law 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date St. Charles Cemetery & 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery of the Resurrection Long Island, New York 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service Live see 22. Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 24 hours after death Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Steaman M.D. 304343 304343Mt. Vernon Rd. Princess Anne, MD 21853 man Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 24

DHMH 17 Rev 1/2001

09-03037 Eric Watkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Eric Watkins		Sta - For State Registrar	ate of Marylan		rtment of tificate of		nd Ment	ial Hyg		g. No.	200	9 1514
Physicia Medical Examin	in/	1. Decedent's Name (First, Middle Eric T. Watk							Date of Deat Month April 16, 20	Day	Year	3. Time of Death 0646 hrs
		4a. Facility Name (if not institution	, give street and number	per)	41	b. City, Town, c			7 tp/// 10, 2	4c. Cour	nty of Death	
Funeral		Cumberland Memorial 5. Social Security Number		Age (In yrs. Ia	st hirthday)	Cumberlar If Under 1 Ye		r 24Hrs.	8. Date of Birt	Allega		hplace (State or Foreign
Director			1XM 2F	Age (iii yis. ia	23 Yrs.	Months Da	_		Dec 2	,	Cou	ryland
*	-	Usual Residence of Decedent		Lie eu					200 2		- 1	10d. Inside City Limits
d now any		10a. State 10b. County Maryland Balt	imore	1	Town or Location							1 Yes 2 X No
larylane 8a-f sh at onc	Director	10e. Street and Number				10f. Zip Code			10	10g. Citizen of What Country?		
h the M 3a or 2		7422 RockRid	ge Rd.			21	208	U	SA			
ath wit items 2	uneral	11. Marital Status 1 X Never Married 2 Ma	med Armed Ford	ces?		Decedent of F s, specify Cuba					Race - Ameri Vhite, etc.	can Indian, Black,
after de	by Fu	3 Widowed 4 Divo	1 Yes	2 X No	1	Yes 2 X N	o specify:			Spec	ify: B1	ack
hours a		15. Decedent's Education (Spec Elementary/Secondary (0-12)			16a. Decedent during mo	's Usual Occup est of working li				16b. Kind o	of Business/I	ndustry
336 thin 72 ne. than *	Completed	12th	College (1-4	(or 5+)	Se	elf Em	p1oye	d		Wr	iter	
15-0(Tiled wi Hygien d other		17. Father's Name (First, Middle,	,					,	First, Middle, I			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	To Be	Richard Watk 19a. Informant's Name/Relationsh			19b. Mailing	Address (Str			M. Co			, Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be potified at once.		Edith Watkin	s(Mother			Rockr				imore		. 21208
Ore, ges 1 an of Hea If iter		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from	n State	Place of Disposi crematory or oth	er place)			Date		•	Town, State
Baltimore, Demit Pages I at Department of Hei Important: If ite		4 Donation 5 Other Sp 21. Signature of Funeral Service		Ch	lews U.	M. Ch						er, Md.
Ba perm Imp Imp		Zanna H Re	10048	3	82	21 Wes	t St.	Anr	napoli	s, Mo	d. 21	
Physician /Medical		failure. List only one cause on each line. Between Onset Death										Approximate Interval Between Onset and
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	Ļ	Sequentially list conditions,	b		0							
	Examiner	if any, leading to immediate										
uted Id ansit												
60, ate be executed hysician and e burial - transit	dica	UNPENDED	AMENDED									
68760, certificate be nding physic		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, or	utcome of preg th		tal death	3 Ectopi	c pregnan	ncy	23d. Da Mor	ate of deliver	y Day Year
Box 6876 he death certificate y the attending physelection in the for use as the	.0	past 12 months? 1 Yes 2 No 9 Unk	noun T	nt at time of de	- 41-	her (Specify)						
O. B at the de d by the	Phy	Part II. Other significant conditi			esulting in the u	nderlying caus	e given in P	art I.	23e. Did t	obacco use	contribute to	the cause of death?
Records, P.O. The law requires that th cate has been signed by page 2 should be detach	ed by				-					s 2 V No		bably 4 Unknown
of Vital Records, ng Physician: The law requir NNer this certificate has been s neral director, page 2 should t	ompleted								24a, Was auto			utopsy findings available completion of cause of
tal Rec	ပ	25. Was case referred to medical		-		26 DI	ace of Death	(Check o	1 ✔ Yes		1 🗸 Y	es 2 No
Vital Physician: hysician: this certifi	o Be	examiner?	Hospital	patient 2	ER/Outpatient		Other 4	-	Home 5	Residence	6 Othe	er:
1 of Jing Ph After t funeral	on: T	27. Manner of Death	28a. Date o	of Injury Day Year) DAYO	28b. Time of I 0200 hrs		njury at Wor		28d. Describe Subject as:		occurred	
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Division pital or Atten ours after death teral Director:	ertifi		a not be	Jail/Penal	o, o	.,,,			or Town.	State)		mberland, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal C	29a. Certifier (Check only one) Certifying PI	nysician: To the best miner:On the basis o	of my knowled	ge, death occur	red at the time	date and pl	lace, and	due to the cau	ise(s) and m	anner as sta	ted.
To 11 Withi To 11	Medi	29b. Signature and title of certifie	and manner sta	ated.			ense number		. Ino timo, dan			onth, Day, Year)
	-	William B	innell!	MA		C.M.E.	April 1	7, 2009				
A		30. Name and address of person				onn Street	Roltime	ro MD	21201			
Hw St	tate	Melissa Brassell, MD 31. Date filed (Month. Day, Year)	Assistant Med	gistrar's Signat		Penn Street	, Dalumbi	· · · · ·				
Regis	trar	APR 24 7	1119 12		600	21						

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan	-	artment of F rtificate of I		and Mo		giene Reg. No 1	09	151	43
	Physicis	an	1. Decedent's Name (First, Middle, Last							Date of Dea Month		Year	3. Time of	
		hysician								April	23,	2009	10:30	<u>J</u> A ™
7	Examin	er	4a. Facility Name (If not institution, give Suburban Hosp:		ber)		4b. City, Town, or Bethe		of Death		4c. Count	y of Death 1 tgome	rv	
a di	Eupovol		5. Social Security Number 6. Se		. Age (In yrs. I	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da		9. Birthp	lace (State	or Foreign
н	Funeral Director			M 2□F		87 Yrs.	Months Days	Hours	Min.	May 22	, 1921	Wash	. D. (J
	pu ,		Usual Residence of Decedent 10a, State 10b, County			y, Town or Lo	ection					1	Od. Inside C	ity Limits
	faryla i sho v	ō	Florida Palm Bea	ach		ca Rat								2 No
	the N	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Coun	try?	
1/2	filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ent, it a Medical Eracinal must be notified at		20310 Fairway Oaks Drive 33434								S. A.			
	death	Funeral	11. Marital Status	12. Was Deced	002		Was Decedent of H	lispanic Ori	igin? (Spe	cify Yes or No	- 14. Ra	ce - Americ		
36	or it	by Fu	1 Never Married 2 Married	1 AYes 2 If Yes, Give	i no ne	avy	1 □Yes 2 🛣 No					⁄y: Whi		
<u>ö</u>	hours tural	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	es: WW		dent's Usual Occup	ation			16b. Kind of E			
7	in 72 n "na notic	plet	(Specify only highest grad	(Specify only highest grade completed) (Give						ig		Medical		
212	d with giene	Completed	Elementary/Secondary (0-12)	College (1-4		P1	nysician				Med	LCal		
D	be file tal Hy d othe	å	17. Father's Name (First, Middle, Last)							, ,	, Maiden Surna	me)		
yla	ould t	၉	Morris Wechsler			T				Viner		0	0-4-1	
Maryland 21215-0036	d 2 sh thand 7 is n trau⊓		19a. Informant's Name/Relationship (T) Elaine G. Wechsle		e		ng Address <i>(Street</i>) Fairwa y							. /.
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o E	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinant must be notified an once.		1 X Burial 2 ☐ Cremation 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		rate i		id Mem. Go		4/26/	2009	Falls	Churc	n, Vir	ginia
Baltimore,	mit. F partm portar / inju		21. Signature of Funeral Service Licens											
Ö	a II De		Donald C. Lt	ottem	yes #		2. Name and Addre Danzansky L170 Rock					Mary1		
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a y loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o Due to (o Due to (o	Cardiac	e Arres			S Quidido 0				Approxima Interval Be Onset and	tween Death
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ν., σ.	s that ned b	by Ph	Part II. Other significant conditions co			ulting in the u	ınderlying cause giv	en in Part	I.	23e. Did	tobacco use co	ntribute to t	he cause of	death?
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Ö	talor rs afte al Dir	Certification: To	Tionnoide	Donair	9,00. (2,000)									
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		29a. Certifier 1 Certifying Phy (Check only) 2 Medical Exam	iner: On the ba	sis of examina	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	ime, date a opinion, de	and place, eath occurr	and due to the ed at the time	e cause(s) and , date and plac	manner as e, and due f	stated. o the cause	(s)
	To the I within 2 To the I complet	Medical	one) 29b. Signature/and title of certifier	and mann	er stated.		29c. Licens	se number			29d. Date sign	ned (Month,	Day, Year)	
	F 3 F 8		Vilia Illner	rto	w		DO	nhe	-18	2	4123	109		
			30. Name and address of person who d	completed cause	e of death (Iter	m 23a) (Type	, Print)		, , 0		11	/		
			Sima Nourani Zenuz	, M.D.			orgetown	Rd; Ee	ethes	da, MD	20814			
	Sta Registi		31. Date filed (Month, Day, Year) ADD 27 2009	2. Re	egistrar's Sign	ature As au	de de							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	arylan		artment o				gien Reg. N	711119	15144	
			Decedent's Name (First, Middle				2. Date of De	ath		3. Time of Death				
		Physician Nial Franklin					ber			Month April	25.	ay Year 2009	2:45 P M	
and the	/Medio		4a. Facility Name (If not institution	give street and number;)		4b. City, Tox	wn, or L	ocation of Deal	-		c. County of Death		
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	Funeral				ge (In yrs. I	last birthday)	If Under 1	Year _	If Under 24 Hrs	8. Date of Bir	th Year	9 Birth	place (State or Foreign	
н	Director		217-10-1378	1 M 2 □ F	88	Yrs.	Months D	ays	Hours Min.	05/29/			intry) rvland	
	ъ		Usual Residence of Decedent								176			
	rylan how	_	10a. State 10b. County		10c. City	y, Town or Lo							10d. Inside City Limits	
	e Ma	cto	MD Alle	gany		Cun	berlan	ıd					1∏Yes 2□No	
	or 28	Oire	10e. Street and Number				10f. Zip Co				10g. C	itizen of What Cou	intry?	
	th wi	Funeral Director	45 Marion St	reet				2	1502			USA		
	dea dea	ıne	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Deceden	t of Hisp	panic Origin? (S	Specify Yes or No to Rican, etc.))-	14. Race - Amer Black, White		
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5-	72 h 'natu	ete	15. Decedent (Specify only highes	s Education t grade completed)		i (Give	dent's Usual C kind of work of	done du	ion <i>ring most of wo</i>	rking	16b. 	Kind of Business/I	ndustry	
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Jar	2 sh h and ris n	100	19a. Informant's Name/Relationsh			1				ural Route Numb e, Cresa		or Town, State, Z	ip Code) 21502	
Baltimore, Maryland	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Medical Examination in the Indiffied at once.		Ronald F. Webe	r / Son	001 0					Date		Location - City or		
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all all	permit Depar Impor any In once.		21. Sich ture f Funeral Service I	icensee									nlome, P.A.	
ш	20 E 8 9		Delle &	100m			104 Dec	atu	r Stree	t, Cumbe	erla	nd, MD	21502	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
4	Physician	i i	Immediate Cause (Final disease or condition	Coron	arv A	Artery	Diseas	se.					Onset and Death >5 years	
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	Examiner		On a section to the secondary	h										
	p +	直	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):						= = =		
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89	ntifica ng ph as th	Jed I	IS SEMALE.											
Box	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			☐ Ectopic pre	an anev				23d. Date of del	•	
Ξ.	dear de att	Sicis	in the past 12 months? 1 □Yes 2 □No	4 Pregnant a			Other (spec					Month	Day Year	
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ğ	w require been sign	Completed by								1 🗆	Yes	2 □ No 3 □ Pr	obably 4 Unknown	
ပ္တ	aw re	Set								24a. Was		24b. Were au	topsy findings available	
æ	The law te has age 2 s	E C									ormed2	death?	completion of cause of	
tal	iclan: The certificate ector, pag		25. Was case referred to medical						26 Place of Do	1 ☐ Yes ath (Check only	2 3 N	lo 1∟Yes	2 🗆 No	
5	s cer lirect) Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆	ER/Outpatie	at 3 □ DOA	Other				6 □Other (Spec	-i6.4	
o	ding Physician: The In. After this certificate hit funeral director, page	Li l	27. Manner of Death	28a. Date of Inj	ury	28b. Time o		Injury a Work?	- I rearrang	28d. Describe			sity)	
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is	Atter dea ctor	fica	3 Suicide 6 Could n	ot be 200 Place of in	jury - At ho	ome, farm, str	eet, factory, o	ffice		28f. Location	Street a	and Number or Ru	ral Route Number,	
Division of Vital Records,	after after Dire	Certification: To	4 Homicide	building, e	tc." (Specif	y)				City or To	wn, Sta	te)		
_	spita ours seral		29a. Certifier 1 🛛 Certifyin	g Physician: To the best	of my kno	wledge, deat	h occurred at	the time	e, date and place	e, and due to the	e cause	(s) and manner as	stated.	
	e Hos 24 h e Fur letely	Medical		xaminer: On the basis and manner s	of examina									
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	₩ Me	29b. Signature and title of certifier	. 10			29c. L	icense i	number		29d. D	ate signed (Montl	n, Day, Year)	
			Aluta	Winns				D1	6041		Αŗ	oril 26,	2009	
	3+		30. Name and address of person	who completed equal of	death /Ita-	1 23a) /Tune	Print\							
	nes			Williams,				ial	Avenue	Cumber	land	i, MD 2	1502	
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	Registr		APK 27 20	09 Caner	A.	park	U							

Registrar DHMH 17 Rev 1/2001

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one)

29b. Signature and title of certifier

Ling Li, MD 31. Date filed (Month, Day, Year) and manner stated

no

Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d Date signed (Month, Day, Year)

May 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 6:40 am[™] Hilda H. Weinkam April 27 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Timonium Stella Maris Hospice <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🔀 F 85 01/01/1924 Maryland 216-14-7218 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐Yes 2XNo Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21042 9826 Michaels Way United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐Yes 2 If Yes, Give 2 No 1 ☐ Yes 2√2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rudolph Oliver Huber Dora Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles S. Weinkam Sr. / husbang 826 Michaels Way Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cree 4 ☐ Donation 5 ☐ Oner (Specify Baltimore, MD New Cathedral 04/30/2009 22. Name and Address of Facility 21. Signature of Funera Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Fllicett City, MD 21043 M01411 Interval Between Onset and Death PANCREATIC CANCER Due to (or as a consequence of): Due to lor as a consequence of: Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Examinar must be notified at any Injury or other traumatic event, the "Medical Examinar must be notified at gones.

Baltimore, Maryland 21215-0036

and physician a attending p signed I

Box 68760.

P.0.

Division of Vital Records.

HILDA WEINKHAM

ospital or Attending Physician: The law requires that the death certificate be executed hours after death. this certific al director, After thi within 24 hours after water To the Funeral Director; Aft Certificatio

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23a. Part 1. Ent. r the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail ire. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2**X** No Month Day Year 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ∐Yes 2**X** No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one X Nurse Practitione mer stated.)

(Check only one X Nurse Practitione mer stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and



To the Hospital

State Registrar

Medical

JACKIE JONES, CRNP 31. Date filed (Mon

2300 DULANEY VALLEY RD. Pegistrar's Signature

ress of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4/26/2009 **Physician** 7:00a M Dorothy Lee Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Elizabeth Manor Assisted Living Prince Georges Lanham If Under 1 Year_ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/11/1917 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sev **Funeral** Months Days Hours Min 1 M 2 K 578-12-0549 Washington, DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or with traumatic event, Item Marical Exprinent units be notified at any or other traumatic event, Item Marical Exprinent units be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Greenbelt tX Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10 Southway Unit L 20770 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Statistician Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Fletcher Richmond Viers Claggett ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If Item 27 any injury or other troops. Ruth V. Wilson /Daughter 10 Southway Unit X Greenbelt, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Cem. 5/1/09 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of uneral Service Licenses 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** re ars disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 1 ∐Yes 2550No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

2

31. Date filed (Month, Day,

AV

Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death

6:40 AM

9. Birthplace (State or Foreign

WASHINGTON, DC

10d. Inside City Limits

20785 Approximate Interval Between Onset and Death

Year

1 □Yes

2X No

1 X Yes 2 □ No

Physician /Medical **Examiner**

ohysician and the burial-transit Physician: The law requires that the death certificate be executed Box 68760. as P.O. Records, of Vital Division

1. Decedent's Name (First, Middle, Last) 23^{ay} 200 gear APRTL WHITMORE MARIE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 6 Sex 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours 1 □ M 2 🕱 F SEPT 20 1938 70 Director 578-54-5323 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations to notified at PRINCE GEORGE'S CLINTON Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20735 USA 7304 ROTUNDA COURT 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married_ 2 ☐ Married 1 ∐Yes 2 XNo Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates: 1 ☐ Yes 2 🔯 No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT **SECRETARY** 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked or MARY EWELL THOMAS FLEMING ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7304 ROTUNDA COURT CLINTON, MARYLAND 20735 NATALLIE ELLIS/DAUGHTER permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CLINTON, MARYLAND RESURRECTION CEMETERY 5/1/2009 4 □ Donation 5 □ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part I. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause of the death. Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Lissuss or i jury that initiated events Due to (or as a consequence of): Physician/Medical Examiner resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ADRENAL INSUFFICIENCY 24a. Was an performed' 1 □ Yes 2 🖾 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number D32332 2 BA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 2009 23, APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH K. GUPTA M.D. 9801 GEORGIA AVENUE SUITE 2-20 SILVER SPRING, MARYLAND 20902 APR 2 8 2009 32. Registrar's Signature A. park **ORIGINAL**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 P^M 2009 Marie C Yeager May /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WMHS-Frostburg Nursing & Rehab Center Allegany

9. Birthplace (State or Foreign Country) Frostburg
If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Jul 16, 1918 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F_X MD 220-10-2404 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at MD Frostburg Allegany 1 □ Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 48 Tarn Terrace USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces?✓ 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ 💑 Saltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced white permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natuany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Lillian (Loar) Emerick Gilbert Cleveland Emerick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ridgeley WV 26753 19a. Informant's Name/Relationship (Type. Print) Pamela Barker daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 5/4/2009 MD Cresaptown 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer | Service Licens 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pent Enter the diseas of compilinations that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of evalues by each lifne.

Immediate Caus (final disease or condition resulting in de my)

Due to (or as a consequence of): Approximate
Interval Between
Onset and Death Physician Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autonsy performe 1⊟ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending Natural Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number wornock Shin MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 925 Bishop Walsh Rd Cumberland MD 21502

DHMH 17 Rev 1/2001 Dr

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 23 200^Yg ar 2:50 Р. м Ruth ZIEGLER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) er Spring
If Under 24 Hrs.
Hours Min.
Aug. 28, 1922 Montgomery Holy Cross Hospital Silver 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 103-12-5741 1 □ M 2 □XF Months Days New York 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1150 Kersey 20902 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name *(First, Middle, Last)* **I** ke Son Sonneberg Jenny Miawa 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 1150 Ressey Road, Silver Spring, Maryland 20902 19a. Informant's Name/Relationship (Type. Print) JOan Walter / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beth Israel Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State April 24, 2009 Woodbridge, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fun al Service License 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of):
Pneumonia Sequentially list conditions, if any least to mind the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hiatal Hernia Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 2 No 3 Probably 4 Unknown 1 ☐ Yes Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 1 □ Yes

Physician /Medical **Examiner**

the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

show

MD

Director

Funeral

Completed by

Be

2

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Examinant mast be modified at

and 2 should be filed within 72 hours after death

and Mental Hygiene.

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical δ Completed

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Be မှ To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 \(\sum \) Yes \(2 \) No

27. Manner of Death

2 Accident

3 Suicide

29b. Signature and title of certifier

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

Hospital:

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number D56691

28d. Describe how injury occurred

26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

April 23, 2009

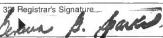
wus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
Ghousia Sultana, 12107 Heritage Park Circle, Silver Spring, MD

State Registrar

Medical

31. Date filed (Month, Day, Year)



To the Hospital within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 200 G **Physician** MA Margaret Anderson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 14 BACTIMORE WARHINGTON MEDICAL (PADE ILEN BURNIE AWHE HZUNIDE If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Year Months 1 □ M 2 ☑ F 505-24-5858 85 Director Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 1512 Holly Road 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14 Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **№** No 1 ☐ Never Married 2 ☑ Married White 21215-0036 1 ☐Yes 2 ☑ No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Is marked other than College (1-4or 5+) 5+ Hygiene. Medical Doctor Medicine Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe and Mental Thomas Joseph McHenry Ruth McDole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important; if item 27 Is any injury or other trau Donald J. Anderson (spouse) 1512 Holly Road, Pasadena, MD 21122 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of May 12 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licensee 3111 Mountain Road, Pasadena, MD 21122 23a. Part I Enter the disease, or complications that caused the shock, or heart failure. List only one cause of each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MONIA /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Por Month Day Year 5 ☐ Other (specify) 1 □Yes ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à The law requires 1 ☐ Yes 2 ☐ No 4 Unknown 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate ! 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) the funeral 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 atural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signa completed cause of death (Item 23a) (Type, Print) Glen Burnie MD 20161 Hornital 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

	1	For State Registrar	State of Ma	•	•	rtificate of			Reg. No.	009	1515
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nysicia: 'Medica	al .		rt Ambro	se				ly.		E Z Z Z Z	
xamine		4a. Facility Name (If not institution, given Saint Joseph	Medical				r Location of Death	on			imore
neral ector		218-22-2323	Sex 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D Sept 2.			pplace (State or Fo intry) y land
12	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City L
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at be	<u></u>	104 Glenmoore Av	enue			21	.030		Ţ	USA	
ar man	Funeral	11. Marital Status	12. Was Decedent E		13.		lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 14.	Race - Amer Black, White	
뉱	by Fu	1 Never Married 2 Married	1 X Yes 2 □ N If Yes, Give	lo		1 ∐Yes 2 MiNo				ecify:	
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9	Completed	07	n/a	''	Co	onductor_				lroad	
event	å	17. Father's Name (First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle	e, Maiden Sur	rname)	
any Injury or other traumatic evonce.	ို	Roland Edw		brose		an Address (Ctron	Edith and Number or Ri		zabeth		allary
traur		19a. Informant's Name/Relationship	,				e Avenue				
other		Ruth Ambrose/Wife 20a. Method of Disposition	е	20b. Pla	ce of Dispo	esition (Name of matory or other pla		Date		ion - City or T	
JO OF		1 M Burial 2 ☐ Cremation 3 D 4 ☐ Donation 5 ☐ Other (Speci				Church (- ; J/ 1	2/09	Cockey	vsvill	e, Maryl
y Indu		21. Signature of Funeral Service Lice	hated (N) A		22	Name and Addre	ess of Facility	a of Du			-
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ner			Due to (or as a								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** May 2009 9:45 <u>Eugene Richard Ackerman</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Lutheran Village Westminster If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 □ F Director MD 213-32-1496 July 30, 1911 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the modical Examinations to set by soliding a 1 ☐ Yes 2 ☑ No Director MD Carroll Westminster 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 USA 1 Bell Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clergy d 2 should be filed w th and Mental Hygien 7 is marked other th Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Mussetta Groshaus Phillip Charles Ackerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 1 Bell Rd., Westminster, MD 21158 Jeanne Mueller-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Franklinville Church 5-15-09 Bradshaw, MD 22. Name and Address of Facility Fletcher Funeral Home, P.A. D 254 Main St., Westminster, MD 21157 E. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Leato disease or condition resulting in death) ma /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an certificate 2 1 □Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Division Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2 29d. Date signed (Monty, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

09-03131 Patricia Ann Anderson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 15	5151	
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		- For State Registrar	Certific	cate of i	Death				R	eg. No.			
Physicia		Decedent's Name (First, Middle,Last)							Date of Dea	th	Vens	3. Time of	
edical Exami		Patricia Ann Anders	son						Month April 19, 2	Day 1009	Year	1107	hrs
		4a. Facility Name (if not institution, give street and n	umber)	4t	. City, Tow	n, or Lo	cation of D				unty of De	ath	
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~ .		5. Social Security Numberunk 6. Sex	7. Age (In yrs. last b		If Under 1	Year	If Under 2	24Hrs.	8. Date of Bi	th(MM/DD/	YYYY) 9. I	Birthplace (Sta	te or
Funeral Director	- 1		" ' '	• • • • • • • • • • • • • • • • • • • •		Days	Hours		Oct 31		For	eign CountrMar	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health is an advected ofter than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Samantha Wyler/daughte		49655						20680		Taura Cta	
Fiter Titer		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal		e of Disposit		of ceme	etery,		Date	20c. Loc	ation - City	or Town, Stat	e
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Balt permit Departi Import injury	6 19	21. Ig and Funeral September Licensee ROTH LOS WALLS	Virector							. Dar	CIMOL	0 0010	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d	, 23a,27,28	20_f n	orME	σR	01 57	713 //	<u> ነው ጥጥ</u>				
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Box 68's death certificate attending and for use as	sician	A No. of Alace Universe	gnant at time of death	5 Oth	ner (Specifi	/)							
the de fe	Phy	9 011	nown						Dia Did	tobacco us	o contribut	e to the cause	of death?
i, P.O. E ires that the d signed by the	by F	Part II. Other significant conditions contributing	to death but not resu	iting in the u	nderlying c	ause gr	ven in Pan	ι.				Probably 4	_
sign lbe c													
of Vital Records, ng Physician: The law requir ofter this certificate has been s meral director, page 2 should I	Completed								24a. Wa aut	s an opsy		e autopsy find to completion	
e law e has	ģ									formed? 2 ✓ No	deat		2 No
tal Rection: The certificate ector, page		05 M			26	Disco	of Death (Check o		2 110		103	
certi	Be	25. Was case referred to medical examiner? Hospital:		210 1 213-1		10	Tther.			Pasidona		Other: Scene	
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of Vital Rec fing Physician: The After this certificate funeral director, page		1 Notural (Mo	te of Injury hth, Day,Year)	Bb. Time of Ir			y at Work?		unk	e now injury	Occurred		
ior tend tor:	atic		4/19/2009	unk_		1Y	es 2 X						
Division tal or Attendi rs after death.	ij	3 Suicide 6 X Could not be 28e. Pl	ace of Injury - At home	e, farm, stree	et, factory, c	office bu	uilding, etc	.				r Rural Route Bayne R	
Divis pital or At ours after d ieral Direct	Certification:	4 Homicide determined (Speci	y) Home					!	Ridge,	MD		ouy ne	
Divisior To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge,	death occur	red at the ti	me, dat	te and plac	ce, and	due to the ca	use(s) and	manner as	stated.	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the bas	s of examination and/	or investigat	ion, in my o	pinion,	death occ	curred at	the time, da	e and place	e, and due	to the cause(s)
T × Z	Me	29b. Signature and title of certifier	Statoy,		29c.	License	number			29d. Da	ate signed	(Month, Day, \	'ear)
		al la l				0.C.N	Л.E.			April	20, 2009	€	
		30 Name and address of name who same	use of death (Itam 05	82)									
1		30. Name and address of person who combuted combarrant Laron Locke MD. Assistant Medi	cal Examiner	_{sa)} 111 Penn	Street.	Baltim	nore, MD	2120)1				
S' Renis	tate	MAY 1 2 2009	www B.	Back	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9 Day 200 4 ar **Physician** 9.158 MA Blakney William /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Washington Medical Center Burnie Arundel Anne 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAR 3, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F Days Hours 216-30-7419 Director 74 1935 South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examples and 1√2 Yes 2 □ No Director N/ABaltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2412 Maisel Court 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. illed within 72 hours after 1 Never Married 2X Married 1 ☐ Yes 2 No Be Completed by If Yes. Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction / Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Laborer Pages 1 and 2 should be filed ment of Health and Mental Hygiant: If Item 27 Is marked other Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lester Blaknev Janie Redfern ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 Maisel Court Mamie L. Blakney, wife 21230 Baltimore, MDBaltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of I Important: If ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 05/11/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACCEDENT CEPEBROVASSULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and give the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
within 14 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760パ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

ABAO 301 Hoppelou Wile

Registrar

0

State

31. Date filed (Month, Day Year)

DHMH 17 Rev 1/2001

BLATIO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Terrance Lee Bu		I- For State Certificate 0		ene 2009 1515
Physicia Medical Exami	in/	Registrar 1. Decedent's Name (First, Middle,Last) Terrance Lee Burkett	N	Date of Death Month Day Year 1123 hrs
		4a. Facility Name (if not institution, give street and number) 1051 Maiden Choice Lane Apt. 1	4b. City, Town, or Location of Death Baltimore	4c. County of Death Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 N 2 F 52 Yr	If Under 1 Year If Under 24Hrs. 8. Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Mary Land Country)
ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca MD Baltimore Arbutus	ition	10d. Inside City Limits 1 Yes 2 X No
or 28a-f sh	Director	10e. Street and Number 915 Elm Rd	10f. Zip Code 21227	10g. Citizen of What Country? United States
death with the ritems 23an	Funeral [11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 X Yes 2 No	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	an, etc.) White, etc.
hours after or 'natural'', o	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year 1974–1976 1 1	Yes 2 X No specify: ont's Usual Occupation (Give kind of work most of working life. DO NOT use retired)	Specify: White done 16b. Kind of Business/Industry
5-0036 led within 72 Hygiene. other than "	Completed		ehouseman 18.Mother's Name (Fir	Food Production rst, Middle, Maiden Sumame)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	To Be (William Austin / father 915	ng Address (Street and Number or Rura Elm Rd. Arbutus, M	
Baltimore, Nermit. Pages I and Department of Healtl Important: If item		1, Burial 2 X Cremation 3 Removal from State Atlantic	other place) Crematory 05/09	20c. Location - City or Town, State /2009 Glen Burnie, MD
Physician injury		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	.328 Sulphur Spring the mode of dying, such as cardiac or re-	rose Funeral Home, Inc. Rd Arbutus, MD 21227 Ispiratory arrest, shock, or heart Between Onset and Between Onset and
'Medical aminer	s 77	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic (heroin) i Due to (or as a consequence of):	ntoxication and coo	5 "
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated unserts condition in additional conditions).		
be executed sician and urial - transit	dical Ex	d. X UNPENDED AMENDED 23a,27,28a-f,	perME, g892 6/4/09	TT
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physici uneral director, page 2 should be detached for use as the buri	sician/Me	past 12 months?	Fetal death 3 Ectopic pregnancy Other (Specify)	y Month Day Year
P.O. B es that the d igned by the e detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown
Records, The law requin ficate has been s, page 2 should I	Completed			24a. Was an autopsy performed? 1 Yes 2 ✓ No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 ✓ No 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Rec pital or Attending Physician: The I ours after death. After this certificate I filled in by the funeral director, page	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 128a. Date of Injury 28b. Time of Death		
Division of Vital I tal or Attending Physician: The street of the This certification of the this certification in by the funeral director,	Certification:	1 Natural 5 Pending Investigation 2 Recident Pending Investigation 28e. Place of Injury - At home, farm, s'	1 Yes 2 X No u	nk 8f. Location (Street and Number or Rural Route Number, City
		Suicide 6 A Could not be determined (Specify) Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	curred at the time, date and place, and du	altimore, MD ue to the cause(s) and manner as stated.
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated. 29b Signature and title of certifier	gation, in my opinion, death occurred at the 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 6, 2009
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21201	
S Regis		24 Data filed (Manth, Day Year) 22 Registrar's Signature	Med	
DHMH 17 Rev 1/2	2001	ORIGIN	IAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13 Month Year **Physician** 200 NEZ /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** timore Rehab Extended CARE Cer Alt nobe If Under 1 Year | If Under 24 Hrs. . Age (În yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. NC 54 25 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examination and insert 1 ☐ Yes 2 TONo Director Millersville Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21108 325 Redwood Grove Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Correctional College (1-4or 5+) 4yrs Elementary/Secondary (0-12) Educator Institutions 12th grade 18. Mother's Name (First, Middle, Maiden Surname) Be (17, Father's Name (First, Middle, Last) Health and Mental Marian Brothers Eliza Barco ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 Redwood Grove Ct, Millersville, Md
21108 Christopher Barco-Son permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 ☐ Bemoval from State 5/15/09 Crownsville, Md Crownsville, Vet 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Si of Funeral Service Licensee 21215 Baltimore, Md 23a. Pan 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancer DION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be execute burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 ☐ Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death.

neral Director: Air 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 ho To the Fune completely f (Check only one) and manner stated. the

State Registrar 31. Date filed (Month, Day, Year) 1

29b. Signature and title of certifie

32. Aegistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWERTHEINER

3900 Loch Raven Blud.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Goldie May 8, 2009 12:50 PM Ann Blankenship /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nottingham

If Under 1 Year | If Under 24 Hrs. | Hours | Min. 4980 Mercantile Road Room 105 Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 048-54-0727 **Funeral** Months 1 ☐ M 2**7** F Director 53 2/22/1956 Connecticut 217-66-7205 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantinat must be notified at once. 10a State 10h County Director 1 ☐ Yes 2 No Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S. A. 1523 Chilworth Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married Married 1 ☐Yes 2 XNo Specify: Specify: ≥ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျ Pillsbury Janet Burwell Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21 Shawgo Court Middle River, Maryland 21220 Michael Iwaniw (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 MOther (Specify)Entombment Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septic 5/vock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Winden Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last imphon burial-trar be exect Due to (or as a consequence of): attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No sulmonay dis ea 24a. Was an page 2 s has autopsy performed?

1 □ Yes 2 ▼No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hotel 1 ☐ Yes 2 📉 No Medical Certification: To this funeral ne Hospital or Attending PI n 24 hours after death. ne Funeral Director: After the pletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and Itle of certifier 29c. License number 00036951 May, 09, 2009 refleredulen and

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Teffrey Schluderberg M) 9114

9114 Philadelphie Rd. Belt Mp 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30P M Month Day Physician Vear 2009 Gladys Joyce lau Bonner /Medical 4a. Facility Name (If not institution, give street and number) County of Death Examiner 4b. City. Franklin Square
5. Social Security Number 6. Se altimore Hospital CENTA Year | If Under 24 Hrs. If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛛 F **Director** 204-20-7725 10/11/1926 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Machinal Examiner must be not filled at Director 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2130 Vailthorn Road 21220 S. Α. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 ☑No Specify <u>ک</u> Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, In. M. College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Reed Stella (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Turnbrook Court Parkville, Maryland 21234
e of Disposition (Name of Date 20c. Location - City or Town, State Diane Michalski (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5/12 2009 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Middle River, Maryland Holly Hill Mem. Gard. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due t (or as a consequence of): disease or condition resulting in death) /Medical Examiner 10 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) endemetrial Caneel the death certificate be executed Metastatic physician ars the burial-tr Due to (or as a consequence of) Box 68760. Physician/Medical attending p as IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes s peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page certificate Vital 1 □Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Medical Certification: To ot funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Prive, Baltimore, MD. 21237 SICG

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9 Day May 200^{Ve ar} Cecelia Ruth Brandt :15 A City, Town, or Location of Death Middle River 4a. Facility Name (If not institution, give street and number) 120 Day Coach Circle 4c. County of Death Baltimore 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day July 19 6. Sex Year) 939 Hours Min. Months Days 1 □ M 2 F 212-38-2570 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County Middle River MD Baltimore 1 TYes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 120 Day Coach Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 TNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Home Care Provider Elementary/Secondary (0-12) 12th College (1-4or 5+) Health 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Knopp 17. Father's Name (First, Middle, Last) Be Williams Sears ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 805 Stone Barn Road Baltimore MD 21286 MArie Sinnott/daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Cemetery 5/12/09 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or conshock, or heart failure. List only prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tastation Years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of) if any, leading to introduc cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only over Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Division of Vital Records, P.O. Box 68760 cate has been signed by the page 2 should be detached certificate funeral director, After this within 24 hours after death. To the Funeral Director: A filled in by the completely the

Physician

/Medical

Physician/Medical Examiner ģ Completed Be Certification: To Medical

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" any highy or other traumatic excessions.

27. Man of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check or

and manner stated.

Registrar's Sig

29b. Signature and title of certifier

one)

29d. Date signed (Month, Day, Year) May 11th 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Non (h.) Six Physical Physical Physical Physical # 208 Ball (6h. U 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ORHIAM Anne 2009 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Cuty Sinci Hospital of BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Hours Months Days 220-82-134 1 □ M 2 M F Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Marylan 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1XYes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Brenda 21212 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>Ş</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Sy I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fill Health and Mental H tem 27 is marked ott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number permit. Pages 1 and 3 Department of Health Important; If item 27 any injury or other tr. once. 2/2/2 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ¹5 ☐ Other (Specify) 4 Donation Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Immediate Cause (Final 14 days **Physician** Multiagan Fai

Due to (or as a consequence of): Failure disease or condition resulting in death) /Medical Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 25 hours after death. 26 Puneral Director. After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2. No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 2 (1/No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 146 Opportuniation injection 24a Was an 2 **1** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 17/10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar Name and ad less of person who completed cause of death (Item 23a) (Type, Print)

MBBS 32. Registrar's 29c. License number

MOSPITAL OF BALTIMORE

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200

			1 - For State Registrar	State of Ma	iryland /		ment of He icate of D		vlental Hy		2009	15163
	Dhyaisi	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De		Year	3. Time of Death
1	Physici /Medio		Joseph H. Bear			- 1			May	8 2	009	6:25 A M
	Examin	er	4a. Facility Name (If not institution, given 741 David Ave	,			.city, lown, or t /estmin	ocation of Death			county of Death ${\sf arroll}$	
	Funeral		5. Social Security Number 6. S		e (In yrs. last bi	irthday) If		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	th		nplace (State or Foreign
	Director		214-32-2555 Usual Residence of Decedent	7	5	Yrs.			10-21	<u>-193</u>		yland
	yland how		10a. State 10b. County		10c. City, Tow							10d. Inside City Limits
	e Mar 8a-f sl	Director	MD Carro	11	We	stmir						1 □Yes 2 ☑ No
	with the		10e. Street and Number			1	Of. Zip Code				en of What Coเ	intry?
	death ms 23	Funeral	741 David Ave	12. Was Decedent B	Ever in U.S.	13. Was	21157 Decedent of His	panic Origin? (S _I , Mexican, Puerto	pecify Yes or N	US.	4. Race - Amer	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, it is "holfed Examination partified at	ğ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	ło		s, specify Cuban Yes 2 ∏ No	, Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify: W	netc. hite
2-0	72 ho "natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	168	(Give kind	's Usual Occupat of work done du	iring most of work	king	16b. Kind	d of Business/I	ndustry
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פט		Be C	17. Father's Name (First, Middle, Last)	1	Drai		18. Mother's Nam	e (First, Middle	, Maiden S	Gurname)	
ylar		To E	Joseph H. Bea					Gladys	Phill	ips	Beaver	
Mar	d 2 should th and Mer 7 is marke traumatic	1 3	19a. Informant's Name/Relationship (Katharine G. Be	,	1	_		nd Number or Ru e. West		-		
ē,	1 an Heal em 2		20a. Method of Disposition	Javel Wil			n (Name of ry or other place,		Date		ation - City or T	
<u>E</u>	Pages nent of ant: If its ury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other <i>(Specit</i>		T .			em. 5-1:	2-2009	Wes	tminst	er, MD
3a1t	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licentee	see the Th	Z					r Fu		Home, P.A.
			23a. Part 1. Enter the disease, or com					er, MD		arrest	254 E	. Main St. Approximate
	Physician	8 1	shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ie.		111		or respiratory t	iii oot,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence		Llung	CALLEL				4 URAYS
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b		-1).						
	uted d unsit	Examiner	Cause (Disease or injury	Due to (or as a	a consequence	or):						
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	T 0) M		IF FEMALE:	23c. If yes, outcome	of pregnancy					2	d. Date of deli	Werv
Box	0 0 0	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		topic pregnancy her (specify)			-	Month	Day Year
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S	w requ	letec	10000	CIONITEC					24a. Was			topsy findings available
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ō	Phys er this eral dir	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injul	nt 2 ER/O	Time of	28c. Injury Work?	4 □ Nursing H	ome 5 Res 28d. Describe			cify)
<u>0</u>	ath. rr: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		, Year)	Injury		es 2□No				
DIVISION	al or Atter after de Directo d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, for a second s	arm, street,	factory, office			(Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: white 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	edical C	29a. Certifier 1 Certifying PI (Check only one) 2 Medical E) at	nysician: To the best of piner: On the basis of and manner sta	examination a	ge, death oo ind/or invest	curred at the time igation, in my op	e, date and place inion, death occu	, and due to the rred at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifler	\supset			29c License	2031		5	gigned (Month	n, Day, Year)
	6 1		30./Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Prin	1)	rivster.	\	0		~
	JV		31. Date filled (Month Day, Year)	SOLUTA 32 Registra	Cotor	Strager	wash	rioster	1001	57		
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DHMH 17 Rev 1/2001

Physician
/Medical
Examiner

Funeral
Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any finity or other traumatic event, I'm Medical Expir her man be notified an any one.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	State of Maryland / De State of Maryland / De	•	rtment of H ificate of D		and M		giene Reg. No	/ 11	09		5164
	Negistrar 1. Decedent's Name (First. Middle, Last)	2. Date						-		3. Tir	me of Death
an	Harry J. Bartholomew					Month May 2,	. 20		Year	2.2	.6 PM M
al	4a. Facility Name (If not institution, give street and number)	\top	4b. City, Town, or	1	. County of	of Death	2.2	.0 111			
er	4222 Main Street		Grasonv					ueen		e's	
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	th		9. Birthr	lace (S	State or Foreign
	214-48-0207 12 M 2 F 60 Yrs		Months Days	Hours	Min.	July 2	$9, \frac{\text{Year}}{1}$	948	Mar	ylaı	nd
	Usual Residence of Decedent									-	
	10a. State 10b. County 10c. City, Town or	Loca	ation						1	0d. Insi	ide City Limits
ţō	MD Queen Anne's Gra	asc	nville							1 🗆	Yes 2 No
rec	10e. Street and Number		10f. Zip Code				10g. Cit	tizen of W	/hat Cour	ntry?	
	4222 Main Street		2163	8				USA			
era		3. W	as Decedent of Hi	spanic Or	igin? (Sp	ecify Yes or No		14. Race	e - Americ	can India	an,
'n	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	If '	Yes, specify Cuba	n, Mexicai	n, Puerto	Rican, etc.)		Black	k, White,	etc.	
by	If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1	□Yes 2XINo	Specify:				Specify:	whi	.te	
Completed by Funeral Director		ecede	ent's Usual Occupa	ation			16b. K	ind of Bu	siness/In	dustry	
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E C	Elementary/Secondary (0-12) College (1-4or 5+) ""	me	chanic				auto	moti	ve		
Ö	17. Father's Name (First, Middle, Last)			18. Moth	er's Name	e (First, Middle,	Maiden	Surname	e)		
Be	Edgar Milton Bartholomew			Mar	gare	t Louis	e Pu	ımphr	ey		
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			Main Str						638	00007	
	20a. Method of Disposition 20b. Place of Di	ennei	ition (Name of		Г	Date	20c. L	ocation -	City or To	own. Sta	ate
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ፟ Donation 5 ☐ Other (Specify)	crema	atory or other place	e) :					,		
			Name and Address			655 W.	Ba1	Ltimo	re S	tre	et
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	23a. Part \ Enter the disease or comblications that caused the death. Do not shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	St	nichve		u İn	non a re	u a	lise	300	Interv	al Between t and Death
	resulting in death) Due to (or as a consequence of):		000, 110				/				
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	Part II. Other significant conditions contributing to death but not resulting in the	e un	derlying cause give	en in Part	l.	23e. Did t	obacco	use contr	ribute to t	the caus	se of death?
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Completed by						1 □ Yes	ormed? 2 No	0 1	1 ☐ Yes	2 N	lo
Be	25. Was case referred to medical examiner?		10"		e of Deat	h (Check only o	one)				
2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			4 LI N	ursing Ho	ome 5 Resi				ify)	
on:	27. Manner of Death 28a. Date of Injury Injury (Month, Day, Year) 28b. Tim		28c. Injur Worl	ζ?		28d. Describe	how inju	ry occurr	ed		
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ŢĮĮ	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, stre	et, factory, office			28f. Location (City or To	Street a wn, Stat	nd Numb le)	er or Rur	al Route	e Number,
Ce											
Medical Certification: To	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, companies to the desired for the desired f	death or inv	occurred at the tire estigation, in my o	me, date a pinion, de	and place eath occur	, and due to the red at the time,	e cause(date ar	s) and ma nd place,	anner as and due	stated. to the ca	ause(s)
Me	29b. Signature and title of certifier		29c. Licens	e number			29d. D	ate signe	d (Month,	Day, Y	'ear)
	> Thum have MD		カコ	386	7		1	5-6	5-1	0	
	30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, F	Stevens	0110	1.1	0 21	101-1	^			
	7HONAS WASHMIN 115 Sall# Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature	-	DEVENIS	VINC	, IVI	1) 41	066	0			
te	31. Date filed (Month, Day, Year) 32. Registrar's Signature A 12 2009	Na									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/		State of Maryland / Department of Health and I For State Certificate of Death		Reg. N	No. 2	009 1518
edical Examiner	1.	Decedent's Name (First, Middle,Last) ALFRED KEENEY BALDWIN	I -	Date of Death Month Da May 4, 2009	_	3. Time of Death 1120 hrs
	48	. Facility Name (if not institution, give street and number) 4b. City, Town, or Lot 30 Locust Street Apt. 208 Westminster	ocation of Death		4c. County of I Carroll	Death
Funeral Director		·	If Under 24Hrs. Hours Min.	8. Date of Birth(N	16	9. Birthplace (State or Foreign Country) MD
	_	sual Residence of Decedent				10d. Inside City Limits
diow any	l	ia. State 10b. County 110c. City, Town of Location WESTMINSTER				1 X Yes 2 No
the Maryland a or 28a-f shr iffied at once Director	1	ie. Street and Number 10f. Zip Code		10g.	Citizen of Wha	
3a or 2		30 LOCUST ST., APT. 208 21157		oif y Ven or No	USA	American Indian, Black,
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland I Hygiene. et other than "natural", or items 23a or 28a-f show it, the Medical Examiner must be notified at once. e Completed by Funeral Director	3	1 Yes 2 X No	Mexican, Puerto R	ican, etc.)	White,	
urs afte	<u>`</u>	Wildowed 4 X Divorced of Yes, Give Year 1 Yes 2 X No. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation during most of working life. D	on (Give kind of wo		6b. Kind of Busi	ness/Industry
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. taut: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. To Be Completed by F	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Elementary/Secondary (0-12) College (1-4 or 5+)				
21215-0036 outd be filed within 72 d Mental Hygiene. s marked other than the event, the Medical To Be Comple	3 1	7. Fattlet 5 Natite (1 11 st, Wildale, East)	8.Mother's Name (KEENEY
2121 ald be fil Mental I marked event,	5 T 7	ALIFICISD WITHJIG STILL 19h Mailing Address (Street a	and Number or Ru	ıral Route Numbe	er, City or Town	, State, Zip Code)
MD 21 d 2 should lith and Mer n 27 is mar aumatic ev		SHARI BOWMAN -SOCIAL WORKER 288 E. GREE	EN ST.,	WESTMIN	ISTER,	MD 2115 / City or Town, State
Baltimore, MD permit. Pages 1 and 2 sht Department of Health and Important: If item 27 is injury or other traumat	2	Da. Method of Disposition 20b. Place of Disposition (Name of ceme crematory or other place)	etery,	Date	LOC. LOCATION -	only or Town, oldico
Baltimore, Department of Her Important: If ite		Donation 5 Other Specify: ALT, COUNTY CREMAT	rion 5/	6/09 L	SYKESV	ILLE, MD L HOME, P.A.
Ball permit Depart Impor injury	Ť	Planed D FIETH DEA E MAI	IN ST.	WESTM	INSTER	, MD 21157
Physician	12	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s failure. List only one cause on each line.	such as cardiac or	respiratory arres	t, shock, or hea	Between Onset and
M-pical miner		mmediate Cause (Final disease or cachinic. Atherosclerotic cardiovascu or condition resulting in death) Atherosclerotic cardiovascu or condition resulting in death)	ular dis	ease		Death
<u>.</u>		Sequentially list conditions, any, leading to immediate but to (or as a consequence of):				
led nsit	Xamilie	Disease or injury that initiated events resulting in death) Last Disease or injury that initiated events resulting in death) Last				- 2
Tra and con	- [평	X UNPENDED AMENDED 23a,27,per ME g892 6/	17/09 TT			
50, ate be exe hysician burial -	Ψ⊢	F FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	•
Box 68760 or death certificate by the attending physical properties of the attending physical	cian/I	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnat	ncy	Month	Day Year
.O. Bc hat the dea ed by the a etached fo	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	given in Part I.	23e. Did tob		bute to the cause of death? Probably 4 Unknown
0 - 1	ed by			24a. Was a	n 24b. \	Vere autopsy findings available
S, P. uires th	E E			autops perforr	ned?	prior to completion of cause of death?
aw requires that the ras been signed by to 2 should be detached by Detached				1 🗸 Yes 2	No 1	✓ Yes 2 No
Records, P The law requires t ficate has been sign, page 2 should be of	5	26 Place	of Death (Check)	oniv one)		
fital Records, P sician: The law requires t is certificate has been sign lirector, page 2 should be completed to	Be	examiner? Hospital: 1 Incatient 2 FR/Outpatient 3 DOA	of Death (Check of Other Nursin		Residence 6	✓ Other: Scene
of Vital Records, P ig Physician: The law requires t there is certificate has been sign meral director, page 2 should be c	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursin			
trending Physician: The law requires t Beath. Jeath. After this certificate has been sign ton: After this certificate has been sign of the funeral director, page 2 should be controlled to the funeral director.	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 5 Pending 1 Notice the state of Injury (Month, Day, Year) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 1 Yes 2 No 28b. Time of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 28c. Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 28c. Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 2 No 1 Yes 3 Notice the state of Injury 1 Yes 3 No 1 Yes 3 Notice the state of Injury 1 Yes 3 No 1 Yes 3 Notice the state of Injury 1 Yes 3 No 1 Yes 3 Notice the state of Injury 1 Yes 3 No 1 Yes 3 Notice the state of Injury 1 Yes 3 No 1 Yes 4 Notice the state of Injury 1 Yes 3 No 1 Yes 4 Notice the state of Injury 1 Yes 3 No 1 Yes 4 Notice the state of Injury 1 Yes 3 No 1 Yes 4 Notice the state of Injury 1 Yes 4 No 1 Yes 4 Notice the state of Injury 1 Yes 4 No 1 Yes 5 No	Other Nursing at Work? Yes 2 No	g Home 5 F	ow injury occur	red
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Rouen 2009 6 BERT 4c. County of Death 4h City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Randallstown Genesis Nuring Home 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1 € M 2 □ F Yrs. Maryland June 29, 1928 80 220-24-2693 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No Pikesville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21208 819 Cliffedge Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ★ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify. Specify White 3 ☐ Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PA Railroad Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Trimbal Louis Bowen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21208 Pikesville, Maryland 819 Cliffedge Road Wife Sadie L. Bowen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 5/13/09 Hampstead, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road M 6 21136 Reisterstown, MD ELINE FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TCREA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: AND Nursing Home 5 Residence 6 Other (Specify) 2100No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 Tes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Datural

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ırai", or Items 23a or 28a-f show i Examiner must be notifled at

"natural", or

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nat any Injury or other traumatic event, the Medica once.

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Completed

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Physician/Medical

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Certification: To

Medical

and attending physician for use as the buria the detached signed I page 2 s certificate completely filled in by the funeral director, this To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

6 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

6 ☐ Could not be

29d. Date signed (Month, Day, Year) 200

né and address of person who completed cause of death (Item 23a) (Type, Print) 2 DRUL SO B

25+1 State Registrar

31. Date filed (Month, Day, Year)

32. Reginar's Signature

	1 - State OT I	Maryland / Depa <i>Ce</i>	rtificate of		rientai Hy	Reg. No. 20	09 1516
Physician	Decedent's Name (First, Middle, Last) Laura H.	Bailey			2. Date of De Month May	8 Day 200	3. Time of Death 3:00pm M
/Medical Examiner	4a. Facility Name (If not institution, give street and numb		4b. City, Town, o	r Location of Death	riay	4c. County o	- John Francisco
/	306 Cantata Court		Reisters				imore
Funeral Director	5. Social Security Number 6. Sex 7. 1 M 2 以 F 7.	Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	4, 1935	9. Birthplace (State or Foreign Country) Texas
and	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ecation				10d. Inside City Limits
Maryl Bed a	Maryland Baltimore	Reisters					1 □Yes 2 No
or 28%	10e. Street and Number		10f. Zip Code	,		10g. Citizen of Wh	· ·
fter death with the Mar r Items 23a or 28a-f si frectors the indiffed Funeral Director	306 Cantata Court 11. Marital Status 12. Was Decede	nt Ever in IIS 13	2113		ooify Vos or No	United 1	- American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Erain in a rist be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Date	∆ No	If Yes, specify Cuba 1 □ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black,	White, etc. Black
72 ho "natur fical	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	oation during most of work d)	ing	16b. Kind of Bus	iness/Industry
within iene. • than in within iene.	Elementary/Secondary (0-12) College (1-4-12) Years 2 year	rs Licens		ional Nurs		Hospita	al
be filed within 72 hours a tal Hygiene. d other than "natural", o event, In Midfall Eran. Be Completed by	17. Father's Name (First, Middle, Last)	!				, Maiden Surname,)
d Ment d Ment narkec natic e	L. V. Winfield			Gladys G			
od 2 st alth and 27 is r r traur	19a. Informant's Name/Relationship (Type. Print) Kendrick Bailey (Son)		_	and Number or Rur rass Driv			tate, Zip Code) land 20646
es 1 ar of Hea litem r othe	20a. Method of Disposition	20b. Place of Dispo			Date		ity or Town, State
. Page tment tant: II fury o	1 → Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	All Saint	s Cemete	ry 5-14-	2009	Reisters	town, MD
permit. Departr Importa any infu	21. Signature of Funeral Service Licensee		2. Name and Addre			uneral H	ome n, MD 21136
	J. Wayne 0s 23a. 7 mt 1 mt fix dise) e, or complications that caushock, or he allure. List only one cause on each	0					Approximate
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should be o					1 🗆	Yes 2 No 3	B ☐ Probably 4 ☐ Unknow
cate has been spage 2 should Completed					24a. Was auto perfo	rmed?	ere autopsy findings available ior to completion of cause of ath?
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ath. rr: Affe ne fune atior	2 Accident investigation	Day, Year) Injury	Wor	ḱ? Yes 2 □ No			
rs after death. al Director: After this led in by the funeral dir Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building,	Injury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
within 24 hours after death. To the Funeral Director: A completely filled in by the ft. Medical Certificati	29a. Certifier 1 ertifying Physician: To the be	est of my knowledge, deat	h occurred at the ti	me date and place	and due to the	cause(s) and mar	ner as stated
ithin 24 hount the Funer ompletely fill	(Check only one) 2 Medical Examiner: On the basi and manner	s of examination and/or ir	vestigation, in my o	ppinion, death occur	red at the time,	date and place, ar	nd due to the cause(s)
withi To the company of the company	29b. Signature and title of certifier	2	29c. Licens			29d. Date signed	(Month, Day, Year)
_	1 1th Bel	وه سا		131612		5/116	39
6	30. Name and address of person who completed cause of Bestern	e 15	Print) Wul	tan	Ane	Rults	mp 22208
State Registrar	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	,				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 200^{Year} lelvin 11:53PM MAY 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE 4413 SUMMER GRAPE ROAD 8. Date of Birth (Month, Day, Year, 08/03/1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. **1**X□M 2□ F 76 Yrs Director 212-30-6880 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Indical Examiner must be notified as once. 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21208 4413 SUMMER GRAPE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. ☐Yes 2X No Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No WHITE Specify. 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BANKING PRESIDENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FERSHTUT SOPHIE BERGER WILLIAM ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4413 SUMMER GRAPE ROAD, BALTIMORE, MD 21208 JEANNE BERGER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State BETH EL MEMORIAL PARKO5/10/2009 RANDALLSTOWN, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sery 22. Name and Address of Facility SOL LEVINSON & BROS 8900 REISTERSTOWŇ ROĀD, PIKĖSVILLE, MD 21208 23a. I art 1. Enter the disease, or commications that caused the dishock, or heart failure. List only one cause on each lin-Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Covia disease or condition resulting in death) /Medical Due to (s a consequence of) Examiner a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown , page 2 should Completed 24a. Was an autopsy performed? 1 □Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier tectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) Dld6725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 N. Caroline GM, och Brown

State Registr<u>ar</u>

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's

AY 1 2 2009

Registrar's Signature

Rowe A. faule

	For State Registrar	State of Maryla	•	rtment of F rtificate of I			eg. No.2009	15169
nysician Medical	1. Decedent's Name (First, Middle, Constance	Last) e Marie Crimy				2. Date of Deat Month	th Y Day Y I ZI, Year	3. Time of Death 29 10:38AM
xaminer	4a. Facility Name (If not institution,	give street and number) oh Medical Ce	nter	4b. City, Town, o		th USON	4c. County of Dea	th Itimore
neral ector	5. Social Security Number 217–03–4788	5. Sex 7. Age (In yrs	s. <i>last birthday)</i> 89Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		year) 9. Bin 20 3alt	rthplace (State or Foreign ountry) C., Maryland
ed at	Usual Residence of Decedent 10a. State 10b. County Maryland Balt:		ity, Town or Loc Cockeys					10d. Inside City Limits 1 ☐ Yes 2 💆 No
the notified	10e. Street and Number	Malcolm Circle		10f. Zip Code 21030		1	og. Citizen of What Co United Sta Of Americ	ountry?
any injury or other traumatic event, the Medical Eventual be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces?	I	Vas Decedent of H f Yes, specify Cuba I □Yes 2½∏No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	OI Americ 14. Race - Am Black, Whit	erican Indian,
ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education	Give life. L	dent's Usual Occup kind of work done o DO NOT use retired ISTPative	during most of wo i)	orking	16b. Kind of Business Parochial	·
To Be C	17. Father's Name (First, Middle, L Patrick Henry					_{ime (First, Middle, I} gina Star		
er traumai	19a. Informant's Name/Relationshi Constance A. Cri		19b. Mailin	g Address (Street 1 Apt. F	and Number or F • Malcol	Rural Route Number M Circle	r, City or Town, State, Cockeysvil	<i>Zip Code)</i> 21030 Lle, MD
ury or oth	20a. Method of Disposition 1	20b. B □ Removal from State Du	Place of Dispo- cemetery, cren Ianey V Memoria	sition (Name of patery or other place alley 1 Gardens	May	14,	20c. Location - City or 'imonium, M	
any inju	21. Signature of Funeral Service Li			Name and Address		ves Furier	al &Cremat	ion Ctr.,P.1 land 21093
cian	23a. Part 1 Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	omplication hat caused the deanly one hause on each line. SEPSIS	th. Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
dical niner	resulting in death)	Due to (or as a conse URINARY b.		INFECTI	ON			
s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse						
or use a	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	d. 23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc	у		23d. Date of de Month	blivery Day Year
p pe	Part II. Other significant condition		sulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	oacco use contribute t es 2 No 3 ☐ P	o the cause of death? Probably 4 ☐ Unknown
rector, page 2 should Be Completed						24a. Was a autops perforr 1 □Yes	ned? death?	utopsy findings available completion of cause of
director	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		Othe	or:	ath (Check only on		
funeral di	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	4 L Nursing		ence 6 Other (Specow injury occurred	ecify)
the ca	1 🛣 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 5 Pending investigation of the suit	t be 280 Blood of tolung At h	Injury nome, farm, stre	M 1 🗆	k? Yes 2 □No	28f. Location (St City or Town	reet and Number or R n, State)	tural Route Number,
completely filled in by	29a. Certifier (Check only one) 1X Certifying 2 Medical E	Physician: To the best of my kn xaminer: On the basis of examin and manner stated.	owledge, death	occurred at the tire estigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
оше	29b. Signature and title of certifier	Sur		29c. Licenso	e number	2	9d. Date signed (Mon	
	30. Name and address of person w	ho completed cause of death (Ite	m 23a) (Type, I	Print)			1 1	

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Examiner attending physician and for use as the burial-trans signed by the a d be detached for certificate has birector, page 2 s this funeral ours after death.

eral Director: A
filled in by the fu within 24 hours a

To the Funeral I

completely filled

Funeral

Director

r 28a-f show notified at

ns 23a or 2 must be n death with

ral", or items 2

'natural",

7 is marked other than "natu traumatic event, the Medical

other t

Department of himportant: If ite any injury or of once.

Physician

/Medical

the

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
HYPERTENS	contributing to death but not resulting in the under			o use contribute to the cause of death 2□ No 3□ Probably 4□Unkr
CHRONIC OBS	TENOTIVE PULMONAP	y Disease	24a. Was an autopsy performed 1 Yes 2	
25. Was case referred to medical examiner?			ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient :	3 DOA Other: 4 Nursing F	Home 52 Residence	6 ☐Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	njury occurred		
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.			
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
P. LEDAR	is MD	047934	MA	174,2009

State Registrar 31. Date filed (Month, Day, Year)

LUSTIAICI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

22

BALTIMORE, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 9:32 2009 **Physician** F. Conelius Helen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. Hours | Min. Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F 90 215-09-8267 MD **Director** 10-11-1918 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2√2 No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event 21061 101 West Mapledale Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 □Yes 2 XI If Yes, Give Year or Dates: 2 📉 No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: à Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Engineer C&P Telephone Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Dressler Richardson William . ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 West Mapledale Avenue Glen Burnie, MD 21061 Mr. Lawrence Conelius, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-09-2009 Lorraine Park Cem. Woodlawn, MD 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemovrhage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 5 Other (specify) ed by the a 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 🗆 No 3 ☐ Probably 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No has autopsy performed? certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 TM0 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division of Vital Records,

Maryland 21215-0036

Baltimore,

Johnel ins

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

> State Registrar

Medical

29a, Certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 36 (icks

and manner stated

Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HUSpotal

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2009 Close Herbert Earle 5 11:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth Month, Day, Year) 2/24/1919 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. Months 1 X M 2 □ F Hours 215-03-0796 Yrs 90 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location MD Anne Arundel Linthicum 1 Tyes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 578 Forest View Road 21090 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Krise (unkn) Herbert Ε. Close 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Craig Close/son 15 Benway Ct. Catonsville MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/2009 Baltimore, MD Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 400 nevoga disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a nonsequince of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

J Hygiene.

permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumatic execution.

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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2009

be executed the burial-trar 68760 attending pl Box Ö ۵. s been signed b should be deta Records, Vital To the Hospital or Attending Physician; Division of

Physician/Medical Examiner Certification: To Be Completed by eral Director: After this certification by the funeral director,

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions		pacco use contribute to the cause of death?
Domenter	, multiple Strokes, 10 Ye	s 2 No 3 Probably 4 Unknown
Attende	heart failure, covonmy 24a. Was ar autops perform 1 years	y prior to completion of cause of death?
25. Was case referred to edical	26. Place of Death (Check only one	e) (/
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside	- 17 :
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		w injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		reet and Number or Rural Route Number, n, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, day and manner stated.	

25205

29d. Date signed (Month, Day, Year)

MAY 6, 2009

State Registrar

Medical

30. Name and address of person who completed cause of tenth (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



6701

within 24 hours after deat To the Funeral Director:

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03692 State of Maryland / Department of Health and Mental Hygiene Deontae Carter Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 8, 2009 0645 hrs Medical Examiner Deontge 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2312 North Rosedale Street 9. Birthplace (State of If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days Country) Mary Director 215-06-1298 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 Yes 2 No s 23a or 28a-f show e notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. rector 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number ä 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital-Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married Yes 2 Yes 2 No specify: f Yes, Give Year Divorced Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) marked other than Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) han Be tenwic and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) Balto Important: If item 27 is injury or other traumatic 312 arand 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Removal from State Bafial 2 Cremation 3 more 100 Donation 5 Other Specify 22. Name and Address of Facility towell permit. 21. Signature of Funeral Service Licenses leights Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death 1 edical a. Multiple Gunshot Wounds Immediate Cause (Final disease miner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED physician a UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE Year Day Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown s been signed by the should be detached t 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o Yes 2 ✓ No 3 Probably 4 Unknown þ Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? icate has b page 2 sh performed' No Yes 2 ✓ Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Physician: Be Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Hospital:, ER/Outpatient 3 DOA Inpatient 2 this 1 ✓ Yes ٩ 28a. Date of Injury 28d Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After t 27. Manner of Death Subject shot Certification: May 8, 2009 0636 hrs Yes 2 ✔ No Pending Director: 24 hours after death 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3000 Blk Elgin Avenue, Baltimore, MD 3 Suicide determined (Specify) Local Street 4 V Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 8, 2009 O.C.M.E.

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year,

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 8, 2009 **Physician** William G. Christoforo 11:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10609 Blue Bell Way Cockeysville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 1**X** M 2□ F Months Days Hours Yrs. 023-20-3716 Director 80 MA May 25, 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar marke northed at Director 1 ☐ Yes 2 X No Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? 10609 Blue Bell Way 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 2 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 □Yes 2 XNo þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Patent Law Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F John Christoforo Lucy Meli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i M. Louise Christoforo/Wife 10609 Blue Bell Way Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens permit. Pages 1
Department of Hi
Important: If iten
any injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State May 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Timonium, MD 21. Signature of Funer Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Flagle 23a. Part +: Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final **Physician** disease or condition resulting in death) CONFEST IVE /Medical Due to (or as a consequence of): Examiner ORONARY Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cobsequence of burial-transi and Due to (or as a consequence of): Box 68760, physician a the burial-The law requires that the death certificate be Physician/Medical signed by the attending place as the detached for use as 23c. If yes, outcome of legnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death IF FEMALE: A A 23b. Was decedent pregnant in the past 12 months? VIA 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) P.O. | ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy performed Yes 2. No this certificate 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation within 24 hours after town...

To the Funeral Director: Aft

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, 32. Reistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUDIN POITSIGO

8320 Bello

Ave Touson Ms. 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** A^{M} Lucille Chapman May 8 2009 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Somerford House Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthdav Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days 1 | M X | F Director 494-18-5089 87 Nov. 27, 1921 Oklahoma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2√☐ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. 7539 Baltimore National Pike 21702 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeping Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Thomas Silas Robb Maud Mae Bernard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>David Chapman / Son</u> 7539 Baltimore National Pike, Frederick, MD 21702
e of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burjal 2 □ Cremation 3 □ Removal from State 4 □ Dollation 5 □ Other (Speofy) Mountain Christian Ch. 5-12-09 Joppa, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Fure 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TYOCARDIAL disease or condition resulting in death) INFARCTION /Medical Due to (or as a consequence of): Examiner ATHEROSC LEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit HYPELIPIDEMIA 745 that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an cate has To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Alzheimais disease 1 ☐Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Vacz A Human M.D. DL686

State

State

31. Date filed (Month, Day, Year)

NAY 1 2 2009

32. Registrar's Signature

NAAZ. A. HUSSAIN, AD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PREBBUCK MD 21702

DRIVE

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Robert L. Croxton, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Seasons Hospice 8. Date of Birth (Month, Day, May 31, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours Months 1 X M 2 □ F 220-20-1703 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be notified at 10a. State 10c. City, Town or Location Director MD Baltimore Co. Owings Mills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 3 Old Coach Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 KYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>salesman</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew F. Croxton Evelyn Garrish ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 218 1/2 Church Ln, Pikesville, MD 21208 Robert L. Croxton, Jr son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet Cem 5/12/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home Reisterstown, MD 21136 com Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician Metastano disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. Tyes 2 No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13W

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Owings MIlls, MD 11824 Reisterstown Rd Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 412 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🔯 No 1 Yes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3. Time of Death

Birthplace (State or Foreign Country)

Pikesville, MD

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Year

2000

Baltimore Co.

Race - American Indian, Black, White, etc.

Specify: white

insurance

241

To the Hospital

State Registrar

29c. License number

fromue SUR 203

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2835 Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Ma	ryland	-	rtment of H <i>tificate of L</i>			giene Reg. No. 2	0 15177
			Registrar 1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea	ath	3. Time of Death
	/sicia ledic:		Catherine Cooper				Month May	8, 2009 Yea	1:25A ^M		
Exa	amine		4a. Facility Name (If not institution, give street and number) Keswick Nursing Home 4b. City, Town, or Location of Death Baltimore						4c. County of De	eath	
Fune	eral		5. Social Security Number 6. So		(In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9 F	Birthplace (State or Foreign
Direc	_		220 02 02-	□M 2□F	72	Yrs.	Months Days	Hours Min.	Dec.	3,1936 Ma	aryland
and	20		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
Maryl H sho	Dec a	io	MD n/a			Balt	imore				1 TYes 2 No
th the	gou a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
ath wil	dist	la	201 N. Washi			t.40				USA	
215-0036 hin 72 hours after death with the Maryland e. en "natural", or items 23a or 28 <u>e</u> -f show	Xaminerin	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba I⊡Yes 2⊡wylo	ispanic Origin? (Sp un, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Al Black, WI Specify:	
I 21 5-0036 Ithin 72 hours aff ne. nan "natural", or	Mudical	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation		(Give	dent's Usual Occup kind of work done o OO NOT use retired	durina most of work	ing	16b. Kind of Busines	ss/Industry
	2		12th			Bar	Manage			Lottie'	s
land in the filed fental Hyg		m	17. Father's Name (First, Middle, Last) George Butle							Maiden Surname) atterson	
laryla 2 should and Men and Men is marke	traumatic	၉ .	19a. Informant's Name/Relationship (7			19b. Mailin	ag Address (Street			er, City or Town, State	e, Zip Code)
md 2 salth an 27 is	er trau		Eric Green (so							Md. 2116	
0 0 -	or other	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		20b. Plac	ce of Dispo	sition (Name of	- 1	Date	20c. Location - City	
timor t. Pages rtment of rtant: If its	land	1	4 ☐ Donation 5 ☐ Other (Specify) [[Gre		ount Cr			Baltimo	
Baltimo permit. Page Department Important: P	any ir	1	24. Ignature of Funeral Service Licen	There	991	1	412 E.	Preston	St. B	eral Homal	21213
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that causes one cause on each lin	the death. e.	Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physic /Medi			disease or condition resulting in death)	a. Crrh Due to (or as a			1405				UNKIONA
Exami				L Due to (or as a	conseque	nice on).					
7D :	H H	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury								
xecute	-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
68 / 60, ificate be executed g physician and	puria puria	<u>8</u>	l	d	, , , , , , , , , , , , , , , , , , , ,	.,,,					
of trifficat	as the	Medical	Je egung								
. Box 68760, death certificate be executed e attending physician and	or use	sician/M	IF FEMALE: 23b. Was decedent pregrant in the past 12 months?	23c. If yes, outcome of	2 🗆 Fetal d	eath 3	Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
_ · Ö o 7	ched	lysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	atn 5L	Other (specify)				
VITAI KECOIDS, P.O. sician: The law requires that the de certificate has been signed by the	ld be deta	d by Phys	Part II. Other significant conditions of	ontributing to death bu	t not resulti	ing in the ur	nderlying cause give	en in Part I.		obacco use contribute Yes 2 □ No 3 □	e to the cause of death? Probably 4 Unknown
aw rec	nous z	Completed							24a. Was	an 24b. Were	autopsy findings available
The The	page	E							autor perfo 1 □ Yes	rmed? death	
Vital F sician: The certificate	ector,	Be (25. Was case referred to medical examiner?	Hognital			l Out-	26. Place of Deat			
VISION Of VITA Attending Physician: If death.	a dir	9	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		R/Outpatier 8b. Time of	nt 3 □ DOA Oth	4 M Nursing Ho		dence 6 Other (S	Specify)
nding aff.: Affe	e rune	atio	1 Natural 5 ☐ Pending investigation	(Month, Day	(, Year)	Injury	Worl	ć? Yes 2 □ No		,.,,	
DIVISION OF all or Attending Physical after death.	a in by th	ertification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						r Rural Route Number,		
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	pietely tilik	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examinatio	edge, deatl on and/or in	h occurred at the til vestigation, in my c	me, date and place	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the	moo	Ž	29b. Signature and title of certifier				29c. Licens			29d. Date signed (M	onth, Day, Year)
			1					29056		5/11/09	
3			30. Name and address of person who	completed cause of de	eath (Item 2	Dorr	Print)	Ball	MC 21	215	
4	Stat	e	31. Date filed (Month, Day, Year)	32. P gistra	r's Signatur	re co ac	riden Rd	rela		•	
Re	gistra	r	MAV 1 2 26	300	a d	9. D	arket				

DHMH 17 Rev 1/2001

Box 68760. P.O. | Records, of Vital Division

or Attending Physiclan: The law requires that the death certificate be executed attending pł for use as tl within 24 hours after death.

To the Funeral Director: A To the Hospital

Funeral

Director

28a-f show

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items 23a

'natural", or

. Pages 1 and 2 should be file trent of Health and Mental H tant: If item 27 is marked out jury or other traumatic even

event, the Medical Examiner must be notified

filed within 72 hours after death with

21215-0036

Baltimore, Maryland

Department o Important: If any injury or once. Physician /Medical Examiner sician and burial-transit page 2 Medical Certification: To à filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELOIR 21236 BRIAN 4 31. Date filed (Month, Day, Year, State Registrar ORIGINAL

Please Type	or Print in	Black Indelible Ink	. Ensure All Copies	Are Legible.
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Ivatore D'Ami		State of Maryland / Department of 1-For State Certificate of Registrar		iygiene Reg.	No. 201	19 1517		
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D May 8, 2009	ay Year	3. Time of Death 1714 hrs		
		4a. Facility Name (if not institution, give street and number) 44	b. City, Town, or Location of Death		4c. County of Death			
Funeral		221 Belle Hill Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Elkton If Under 1 Year If Under 24Hr	s. 8. Date of Birth (MM/DD/YYYY) 9. Bir	thplace (State or Foreign		
Director	9	046-66-7353 1X M 2 F 47 Yrs.	Months Days Hours Mir	Sept 14		nnecticut		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits		
land f show once.	ro	Connecticut New Haven Hamde		Lie		1 Yes 2 X No		
n with the Maryland ms 23a or 28a-f show any be notified at once.	Director	10e. Street and Number 2390 State Street #27	10f. Zip Code 06517	10g.	Citizen of What Could USA	ntry?		
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medie 4 Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces? 12. Was Decedent Ever in U.S. 13. Was lif Ye	L s Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerti	Specify Yes or No- o Rican, etc.)	14. Race - Amer White, etc.	can Indian, Black,		
fter dea l", or it ier mus		1 Yes 2 X No	Yes 2X No specify:		Specify: Wh	nite		
hours a 'natura Examir	ted by		's Usual Occupation (Give kind of ost of working life. DO NOT use re		6b. Kind of Business/	Industry		
036 ithin 72 ne. rr than '	To Be Completed	12 Truck	Driver		Truckir	ng		
Baltimore, MD 21215-0036 eremit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If team 77 is marked other than njury or other traumatic event, the Media.		17. Father's Name (First, Middle, Last) Salvatore D'Amico		ne (First, Middle, Ma Dimartin				
212 hould be and Ment is mark			Address (Street and Number or	Rural Route Number	er, City or Town, State	_		
e, ME and 2 s fealth au traums		20a. Method of Disposition 20b. Place of Disposi	almon Brook Stre		y, GT 0603 20c. Location - City or			
MOre Pages nent of F ant; If i		1 Burial 2 X Cremation 3 Removal from State crematory or oth Metro Crem	natory Inc. 05,		Baltimore,			
Balti permit. Departir Importa	1 (0)	21. Signature of Funeral Service Lieusee Thomas Gregor	ame and Address of Facility emation Society Frederick Road	of Maryl	and, Inc.	and 21228		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Oxycodone and dia	e mode of dying, such as cardiac zepam intoxicat	or respiratory arres	, shock, or heart icating	Approximate Interval Between Onset and		
/Medical :aminer		Immediate Cause (Final disease or condition resulting in death) a. <u>dilated cardiomyopa</u> Due to (or as a consequence of):				Death		
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lest						
und cuted		d.						
O, e be exe ysician a	Medical	UNPENDED XAMENDED 23a,27,28a-f,p	erME, G891 5/21	1/09 TT	23d. Date of deliver	7		
6876 ertificat iding ph		23b. Was decedent pregnant in the past 12 months?	nancy		Day Year			
Box e death o the atter	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	her (Specify)					
Vital Records, P.O. Box 68760, Asirian: The law requires that the death certificate be executed this certificate has been signed by the attending physician and Idirector, page 2 should be detached for use as the burial - transit	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to 2 No 3 Pro	o the cause of death? obably 4 Unknown		
Division of Vital Records, P.O. Is a or Attending Physician: The law requires that the rate death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed			24a. Was ar autopsy		utopsy findings available completion of cause of		
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/ital sician: is certif director,	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Chec		esidence 6 🗸 Othe	er: Scene		
n of V ling Phy After th funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of In		28d. Describe ho	w injury occurred			
'iSiOr Attender er death rector:	fication	2 Accident Investigation Fd 5/8/09 Fd 5:0	15 pm		reet and Number or R	tural Route Number, City 1e Hill Rd		
Div spital or nours aft neral Di	Certification:	4 Homicide determined (Specify)		[Elkton,	MD			
Division of Vital To the Hospital or Attending Physician: within 24 hours after dette. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	red at the time, date and place, at tion, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as sta nd place, and due to t	ited. he cause(s)		
5 1 × 5 0	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)		
88		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		May 9, 2009			
D76c		Ana Rubio MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 212	01				
Si Regis	tate trar					_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep State Amend Item 23a per dr.,g891,052	partment of Heal 12/09dhb ertificate of Dea	ith and Me ath	ental Hygi Re	ene g. No.2 N N Q	15180
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Geraldine Kathleen	Ebberts		2. Date of Death Month	Day Year	3. Time of Death 4:00 P. M
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca		May 4	4c. County of Death	
لر	Examin	er	7550 Jenn Drive	Woodbi			Carrol1	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U		B. Date of Birth (Month, Day,	9. Birth	place (State or Foreign
	Director		235 48 5516 1□M 2☑F 76 Yrs.	Monate Baye 116		05/16/1	1932 Wes	t Virginia
	and		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or L	ocation				10d. Inside City Limits
death with the Maryland	Maryl	ţo	Maryland Anne Arundel Glen E	Burnie				1 ☐ Yes 2X No
	r 28a	irec	10e. Street and Number	10f. Zip Code		10	Og. Citizen of What Cou	intry?
	23a c	ra D	102 North Crain Highway #270	2106	51		U.S.A.	
õ	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or litems 23a or 28a-f show event, the Markeal Evan Than must be notified at	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☐ Married	S. Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 【 No Sp	nic Origin? (Spec lexican, Puerto R pecify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White, Specify: 1,11-	, etc.
5-0036	within 72 hours after iene. than "natural", or ite		3 ☑ Widowed 4 ☐ Divorced Year or Dates:	andont's House Conunction			WI:	nite
ς c	in 72	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during . DO NOT use retired)	g most of working		100. Kilid di Business/il	idustry
7	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) Lo	bby Person			McDonalds	Restaurant
and	be filed Ital Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)	18. !			faiden Surname)	
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Mar	2 sh n and ris m		1 1 2 1	iling Address (Street and N				
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altimor	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evone.		1 Burial 2 La Cremation 3 Li Hemoval from State	position (Name of ematory or other place) Crematory	05/08		Baltimore,	
	nit. P artme ortan injur		· · · · · · · · · · · · · · · · · · ·	22. Name and Address of		,	ral Service	
ä	permi Depa Impo any it	ď (4001 Ritchie	0011	y Balt	imore, Mary	land 21225
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A metastatic Ut Due to (or is a consequence of): Due to (o	erine Cance	r	respiratory arre		Approximate Interval Between Onset and Death O months
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to () ras a consequence of):	ne 070	ring	Cano	40	6 monthy
Po+	uted d ansit	Examiner	cause. Enter Underlying Cause (pisease or injury that initiated events c.	- Melle	tos			10 years
Ď.	icate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):					
0/00 0/00	ate be hysici he bu	dical	d					
O. BOX 68 he death certifica	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death: within 24 hours after death: completely filled in by the funeral director, page 2 should be detached for use as t	Completed by Physician/Med		B			23d. Date of deli Month	very Day Year
as, r.	uires that I signed by Id be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in	Part I.	23e. Did tob	oacco use contribute to	the cause of death?
The law requires #	: The law req cate has beer page 2 shou					24a. Was ar autops perforn 1 🗆 Yes 2	y prior to o ned? death?	topsy findings available completion of cause of
VII	ician certifi ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		. Place of Death	(Check only one	e)	
5	Phys r this ral dir	2	1 Yes 2 No Inoshian 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time				ence 6 Other (Spec	oify)
DIVISION SHOP	I or Attending after death. Director: Afte I in by the fune	Certification:	1	Work? M 1 □Yes	2 □No		reet and Number or Ru	ral Route Number,
	e Hospita 24 hours e Funeral	Medical C	29a. Certifier (Check only one) 1 • Certifying Physician: To the best of my knowledge, de. 2 • Medical Examiner: On the basis of examination and/or and manner stated.					
	To th within To th	Me	29b. Signature and title of certifier (Mr)	29c. License nun	mber 9 4	2	9d. Date signed (Month	i, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Ellicott For hay mon 1411 Ward		Drug (Len Du	race, ind	206/
	Sta Registr		31. Date filed (Month, Day, Year) 82./Registrar's Signature	Had	r			

DHMH 17 Rev 1/2001

			for State Registrar			ryland / [Cer	rtificate of l	Death	-	Reg. No.	2009	15181
	Physici	on	1. Decedent's Name (Firs	st, Middle, Las	t)	1				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Mary	Eva						May	9	200	
	Examir	er	4a. Facility Name (If not in		,				Location of Death		4c.	County of Deat	h
er .	Francis		Genesis 5. Social Security Number			(In yrs. last bir	rthday)	Brook 1 If Under 1 Year	yn Park	8. Date of Bir	th	nne Ar	undel hplace (State or Foreign
	Funeral Director		246-46-67	4.1	□M 2 X 1F 79	, ,	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Co	NC
	ъ		Usual Residence of Dece							0-/-1	929		
	arylar show	-	10a. State 10b.	County		10c. City, Tow							10d. Inside City Limits M☐ Yes 2 ☐ No
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	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be routlind at		10e. Street and Number 2807 Whit	- 0 110	n 11 A			10f. Zip Code 2 1 2 1 4			•	zen of What Co SA	untry?
	leath ms 23	Funeral	11. Marital Status	, e nve	12. Was Decedent E	ver in U.S.	13. V		ispanic Origin? (Sp	ecify Yes or No)- /	14. Race - Ame	rican Indian.
9	after o	Fu	1 ☐ Never Married 2	2 ☐ Married	Armed Forces? 1 □Yes 2√N If Yes, Give			fYes, specify Cuba I∐Yes ŽŽNo	ispanic Origin? (Spanic, Mexican, Puerto	Rican, etc.)		Black, White	e, etc. African
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7	within ene. than	Completed	Elementary/Secondary	(0-12)	College (1-4or 5-	D (stic	")		Hom	emake	:
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au	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	TO B	Nelson	H	lenderson				Carrie	Не	ende	rson	
Maryland 21215-0036	ar ai	Г	19a. Informant's Name/R			19b	o. Mailin	g Address (Street	and Number or Run Avenue I	al Route Numb	er, City o	Town State	Zip. Codg)
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Baltimore,	Pages 1 nent of H int; if ite iry or ot		20a. Method of Dispositio 1 ☐ Burial 2 🛣 Crer	emation 3 🗆		cemete	ry, cřen	sition (Name of natory or other plac	e)	Date		cation - City or	
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Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral	Service Licens	Mes)							MD 21217
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4	Physician	Ò	Immediate Cause (Final disease or condition		a. Cong	estiv	e	Heart	Faile	ire			Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a	consequence	of):						
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	cuted id ansit	Examiner	ir any, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	~	HYPE	2RTS	NS	NOI					
0	ifficate be executed g physician and as the burial-transit	Ex	resulting in death) Last		0.	consequence							
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0	requires that the death certific een signed by the attending p nould be detached for use as	Physician/M	23b. Was decedent pregr in the past 12 month	nant	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at	Fetal death		Ectopic pregnanc Other (specify)	У		2	23d. Date of de Month	livery Day Year
Box	w requires that the de been signed by the a should be detached to	nysi	1 □ Yes 2 🕰 No 9 □ Unknown		9 Unknown								
o.	s that gned b	by PI	Part II. Other significant	conditions or	ontributing to death bu	t not resulting in	n the ur	nderlying cause give	en in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
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l Records, P.O.	The law ate has b age 2 sh	Be Completed I	25. Was case referred to examiner?	-	Managari,			·	26. Place of Deatl	1 24a. Was auto perfo	Yes 2[an psy primed? 210 No	24b. Were au prior to death?	robably 4 d Unknown utopsy findings available completion of cause of
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Evans

Mary

Dec:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:30^P M ďŎ, 2009 Joseph H. Evans 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Oak Crest Care Center Parkville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours Months Davs 1**欠** M 2□ F 220-14-6301 86 01/22/1923 Baltimore, Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Parkville Baltimore 1 ☐ Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8800 Walther Blvd. #2402 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WW If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married WWII 1 ☐ Yes 2 🛛 No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Clerical Circuit Court 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph J. Evans Mary B. Kreiner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian McFarland/Attorney 920 Frederick Rd. Catonsville, MD 21228 20b. Place of Disposition (Name of Evans Fune Late) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 05/11/09 Forest Hill, MD Chapel- Bel Air 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 nature of Funeral Service Licensee of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or liep it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final esus dise se or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner burial-transit the attending physician P.O. Box 68760 the signed by the attending be detached for use Division of Vital Records,

Physician/Medical Aner this certificate has been s funeral director, page 2 should I Completed Be Certification: To

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Examine

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hujvo or other traumatic event, the Moden Exprise must be nutilised and any hujvo or other traumatic event, the Moden Exprise must be nutilised and

Physician

/Medical

Baltimore, Maryland 21215-0036

Hospital or Attending 24 hours after deatle Funeral Director: completely filled in by the

State

Medical

25. Was case referred to medical examiner? 1 Yes 2 No

29a. Certifier

(Check only one)

27. Manner of Death 5 Pending investigation 1 Natural 2 ☐ Accident 3 Suicide

6 □Could not be 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certifier THEID CRAP-

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTHER BLUD BATTO MD 21234. 8832 Justine

31. Date filed (Month, Day, Year)

Registrar

within 2 the

09-03597 Anthony Egger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg. No.	010
Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year OO 45 by	
ledical Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		601 Parkwyrth Avenue Baltimore	
Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Months Days Hours Min. 06-21-1960 Foreign Country)	d
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	
* .	5	Md Baltimore 1XYes	2 No
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mornal Hygiers with the Maryland term 27 is marked other than "natural", or items 23a or 28a-f sho tranmatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 601 Parkwyrth Avenue 10f. Zip Code 21218 10g. Citizen of What Country? USA	N- ol
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ours aft atural" camine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
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212 ould be Menta mark ic even	To Be	19a Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	C
MD nd 2 shc alth and m 27 is		Jacqueline Egger Wite Vaughn O Greene 4 Baltimore, MD 21239	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Opparment of Fleath and Montal Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med		1 Burial 2 Cremation 3 Removal from State crematory or other place	
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Balti permit. Departn Imports		Caughn C. Frene 4905 York Rd. 78alto., Md. 21212	
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sit	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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750, icate be execute physician and the burial - tran	Medica	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
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tal Recorcian: The law rector, page 2 sh		25. Was case referred to medical 26.Place of Death (Check only one)	No
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Division of Vital Records, tal or Attending Physician: The law requirent staffer death. Juredore. After this certificate has been siden by the funeral director, page 2 should be a fine by the funeral director, page 2 should be a staffer to the funeral director.		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot	
or sath.	catic	Natural 5 Pending Investigation 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route N	umber, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family Apt. Or Town, State) 601 Parkwyrth Avenue, Baltimore, MD	
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one) 29a. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To To Com	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ar)
		Carol Hallan O.C.M.E. May 5, 2009	
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regis			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day May 2009 3:50 A [™] Helen Claire Fahnestock /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Havre De Grace Harford 229 North Union Avenue Apt.1B If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 13, 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🛛 F Months Days Hours 214-46-8713 1946 England Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Maryland Havre De Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 229 North Union Avenue Apt.1B 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🏖 No Specify. White Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Charles Reiter Ethel Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Jackson, Daughter 626 Pearl Street Havre De Grace, Maryland 21078 Itimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/12/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee/Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician and Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 1□ Yes 2 No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

filed (Month, Day, Year) NAY 1 2 2009

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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FOWLER HELEN 1:00 P M 2009 MAY 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHABILITATION FOREST HILL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 7 - 20 - 19 24 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2√2 F 217-12-3389 84 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show up yo rother traumatic event, the Marical Exercise must be notified at ury or other traumatic event, the Marical Exercise. 1 ☐ Yes 2 XNo Harford Director Md Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 109 Forest Valley Drive 21014 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3X Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Graham Madaline Busick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Steven C. Fowler 209 Meadow Road BelAir, Maryland 21014 Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 5-13-09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Funeral Sep/ce Ligensee 263 S. Conkling St. Balto. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** end 3 mye resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U.S. or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, iis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ryperten autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No nothe Be 25. Was care referred to midical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural n 24 hours after death.

The Funeral Director: After the fulled in by the further fulled in by the further further fulled in by the further fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 032295 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN - 615 WEST MACPHAIL ROAD - BEL AIR, MD 21014 32. Pégistrar's Signature 31. Date filed (Month, Day, Year) State MAY 12 2009 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar 30. Name and

31 Date filed

Month, Day,

Box 68760.

P.O.

Division of Vital Records,

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:30 p MAY 6 2009 Ronald Glascoe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore Future Care Lochearn | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 16, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1944 **Funeral** 1 X M 2 □ F 216-42-4083 64 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 28a-f show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the "Marical Examiter must be notified at 1 X Yes 2 ☐ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 USA 511 North Robinson Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examining once. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Black 5 4 1 Specify. Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Patterson Albert Glascoe ع 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 511 North Robinson Street Baltimore, Maryland 21205 Tanya Glascoe, Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc.: 05/08/09 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Cremation Society Of Maryland, Inc. 21. Signature of Funeral Service License Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCHEROTTE FREBRO Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably iis certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 212 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 285 allaun uell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AICHANI, 2835 JASN EEM

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12:25 P ^M 2009 May 10, Karl William Gruss /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Jan. 30, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1916 Hours 1 X M 2 □ F 93 Maryland Director <u> 212-05-7182</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be matified as 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2 No Directo Queen Anne's MD Church Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 215 Walnut Street 21623 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White Specify: 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas Elementary/Secondary (0-12) College (1-4or 5+) and Electric Finance Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karl Gruss Anna M. Reich ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 215 Walnut Street, Church Hill, MD 21623 Anita Gruss - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria Z ☐ Gramation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5-13-2009 Odenton, Maryland Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. ▶ 1328 Sulphur Spring Rd., Arbutus, MD 21227 Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

defiate Cause (Final assert condition Immediate Cause (Final **Physician** disease or condition resulting in death) / /Medical Examiner De Sequentially list conditions, Physician/Medical Examine if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □Yes 2 □ 40 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 3 - NO 1 Mpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, I

30. Name and address of person who completed clause of death (Item 23a) (T

Registrar's Signatu

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29d. Date signed (Month, Dav. Year) 10

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2009

600 North Wolfe St, Baltimore, MD, 21287

Lungman, MEDICAL DOCTOR

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTINA
31. Date filed (Month, Day, Year)

		,	1 - For State Registrar	State of Marylan		artment of F			iene _{eg. No.} 2 ()	09	1519
	Physici /Medi		1. Decedent's Name (First, Middle, Las Anna M. Gettie	,				2. Date of Death Month May 6,	Day	Year	3. Time of Death 7:00 P M
-	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	, ,	4c. County		
			27 Queen Anne Rd.			Glen Bu		9 Date of Birth		Arund	
	Funeral Director		5. Social Security Number 6. S 1 214-46-2423 Usual Residence of Decedent	ex 7. Age (In yrs. 94	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 1,		Mary1	ace (State or Foreig try) Land
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10	d. Inside City Limits
	r 28a-f sh	Director	Maryland Anne Ary	undel Gle	n Burn	ie 10f. Zip Code		10	0g. Citizen of	What Count	1 □ Yes 2√2 No try?
	th with	a D	27 Queen Anne Rd	•		21060		1	Unite :	States	3
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "McCal Eventher unit be northed.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🙀 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ick, White, e fy: Whi	etc.
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	filed within Hygiene. Ither than "		8		Homen	aker	40 Matterda Name		Own Hor		
and	ould be fil Menta! H arked otl atic ever	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			nej	
Maryland	should and Mer s marke umatic	2	Howard I. Hunt 19a. Informant's Name/Relationship (Type Print)	19b Maili	na Address (Street	Barbar	a Mary A.		. State. Zip	Code)
	and 2 sho ealth and I n 27 is ma			Daughter			view Rd.,	Brook1			21225
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 i		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Dopation 5 □ Qther (Specif	Removal from State	Place of Dispo cemetery, cre	osition (Name of matory or other place ark Cemet	! !	9.	20c. Location		wn, State aryland
Balti	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service Dicer	1,10		2. Name and Addre	ess of Facility Ruddick F n Hwy. SE	uneral H	ome, P	.A.	21061
	ate be executed which will be a secured with the purish transit and the purish transit are the purish transit and the purish transit are	ical Examiner	23a. Part1: Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Compared to the consequence of the co	2 HYTHM uence of): (e auzī uence of):	MAS-2Nd	Degree AVI	Block/Con	nplete Ite		Approximate Interval Between Onset and Death
P.O. Box 68	Physiclan: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnanting the birth 2 Feta 4 Pregnant at time of 6 9 Unknown	Ideath 3	□ Ectopic pregnand	су			ate of delive	ery Day Year
σ.	s that ned by detail		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use cor	ntribute to th	ne cause of death?
rds	w requires that s been signed t should be det	ed by	Coronary artery	disease Hy	perli	pidemia	,	1 □ Ye	es 2 🗆 No	3 ☐ Prob	ably 4 🔀 Unknow
of Vital Records,	: The law recate has bee	Completed		Thramboayt				24a. Was au autops perforn	ned?	. Were autor prior to cor death? 1 \(\sum Yes	psy findings availabl mpletion of cause of
ta	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 th (Check only on	****	ILL 162	2 🗆 110
f V	nysiclan: nis certific director,		examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 □ DOA Oth	ner: 4 Nursing Ho	ome 5 🔀 Reside	ence 6 🗆 Ot	ther (Specifi	y)
Division o	Attending death. ctor: After y the fune	Certification: To	27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Sulicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		28b. Time of Injury ome, farm, st fy)	M 1 🗆	ry at rk?]Yes 2 □No	28d. Describe ho 28f. Location (St City or Town	treet and Num		l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical Cer		nysician: To the best of my kno niner: On the basis of examina and manner stated.							
10	To the within ? To the comple	Med	29b. Signature and title of certifier	and mainer stated.	Jens G	29c. Licens	se number	a l	9d. Date sign		Day, Year)
			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)					
			Ana Martinez, N		Mounta	in Rd.	Pasadena,	MD 211	122		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature de la company	. 1					

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland	/ Department of H Certificate of I		ntal Hygier		13132
ı	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last ROV AnderSOr	" Gallop Sr.	,		MAY S	Day Year Zoog	3. Time of Death
)	Examin Funeral	er	4a. Facility/Name (If not institution, give 2212 Hamilton 5. Social Security Number 6. S 220-20-5114	r Circle		If Under 24 Hrs. 8 Hours Min.	Date of Birth	4c. County of Death KAITI 9. Birthp Cour	MITU place (State or Foreign place), MITU
	Director show		Usual Residence of Decedent 10a. State 10b. County M.)	Fimore 10c. City,	Town or Location Rosedale		<i>V</i> 11	1	l0d. Inside City Limits 1 ☐ Yes 2 X No
	th with the 23a or 28s	al Direc	10e. Street and Number 2212 Hamiltor	Circle	10f. Zip Code 212	31		Citizen of What Cour	
980	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show I.a Modeal Exactinar must be ricitlised at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cubi	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:		14. Race - Americ Black, White, Specify:	lack
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, Ite Modical Examination at the nutilised at once.	Completed by Funeral Director	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working d)	Je	Food S	
Maryland	ould be filed Mental Hygis wrkad other hatic evant, II	To Be (17. Father's Name (First, Middle, Last, Junes Gulluf	o St		18. Mother's Name (Hughe	5	0-41
	and 2 sho lealth and m 27 is my her traum		Donald Gallor	Son	19b. Mailing Address (Street 2212 Hami It co of Disposition (Name of	on Circle Da	Koseda	ty or Town, State, Zip Le Malle Location - City or To	237
Baltimore,	Pages 1 ment of H ant: If ital ury or oth		20a. Method of Disposition 1	Removal from State Gar	metery, crematory or other pla VISM FORES	t 5/181	109 Ou	ungs M.T.	s, Md
Balt	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Lice	J. Mreine	Vaughn C. C	frune, 49	5 York L	d Ratto	Md 2/2/2 Approximate
8760, A	Cate be executed / Medical Examiner in the burial-transit	dical Examiner	23a. Part1. Enter the disease, or composition of heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	ence of):			T	Interval Between Onset and Death Our (o
.O. Box 68	death certiff e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 Ectopic pregnanc	:y		23d. Date of delin	very Day Year
Δ.	uires that the signed by does do be detact	by	Part II. Other significant conditions Diagrams	contributing to death but not resul		ven in Part I.		co use contribute to	the cause of death?
I Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed					24a. Was an autopsy performe	d? prior to c	topsy findings available ompletion of cause of
f Vital	ysiclan: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3□ DOA Ot		ne 5 Mesideno	e 6 □Other (Spec	ify)
Division of	Attending death. ictor: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not 1 4 Homicide	(Month, Day Year)	M 1 [me, farm, street, factory, office	ork? □Yes 2□No	8d. Sescribe how 8f. Location (Stree City or Town, 3	et and Number or Ru	ral Route Number,
Ö	To tha Hospital or within 24 hours after To the Funaral Dirac completely filled in b		29a. Certifier 1 YCertifying P	hysician: To the best of my know	vledge, death occurred at the	time, date and place, a	nd due to the cau	se(s) and manner as	stated.
	Fo tha Howithin 24 Inc. To the Fusion posterior	Medical	(Check only 2 Medicel Execute) Medicel Execute 29b. Signature and title of certifier	miner: On the basis of examinati and manner stated.	29c Licen	se number	290	. Date signed (Month	n, Day, Year)
			30. Name and address of person who	completed cause of death (Item	23a) (Type, Print) Y E Y E Ura	42523	V	uly 8,	2009
	<u> </u>	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ura) 4 E YS	Ecste	n M	r. Be	1224
	Regist		MAY 1 2 2009	Cenus S.	park				1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8:38 am MATTIE MARIE GOODS ria 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nor 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 □ M 2**X** F 218-46-9925 **Director** NC FEB. 28, 1946 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Exacting must be notified at 1 Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 400 N. LAKEWOOD AVE 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 0 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOUSEKEEPER HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ဥ WALTER BOWDEN CARRIE LAWSON Department of Health and Important: If item 27 Is m any injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOWANDA GOODS/DAUGHTER 400 N. LAKEWOOD AVE., BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5712 O DONNELL ST. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/15/2009 BALTIMORE, MD 21224 MT. CARMEL 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary astery WKN DW /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit Examir Division of Vital Records, P.O. Box 68760, 🌣 Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1∐Yes 2⊡Mo sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, t or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ٥ 1,2009 D47353 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

alce

2

31. Date filed (Month, Day, Year)

2000

HUSA: tal

Registrar's Signature

900 Cuton Avenue

Bultimore, Mayland

09-03392 Herbert Garrett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009	51	91
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	1- For State C Registrar	ertificate of Death	Reg. No.	, 1015
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) Herbert Garrett		Month Day Year April 27, 2009	ime of Death
	4a. Facility Name (if not institution, give street and number) 4310 Jefferson Street # 104	4b. City, Town, or Location of Death Hyattsville	Prince George's	
Funeral Director	5. Social Security Numberink 6. Sex 7. Age (In yr	s. last birthday) If Under 1 Year If Under 24Hrs 65 Yrs. Months Days Hours Min	Foreign	Aaryland
Maryland 28a-f show any d at once. ector	Usual Residence of Decedent 10a. State	City, Town or Location Hyattsville	1	d. Inside City Limits Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 4310 Jefferson Street 3104	10f. Zip Code 2078	10g. Citizen of What Country? USA	
"hours after death w "natural", or items Examiner must be ted by Funer.	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+)	unk If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify: 1 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	Rican, etc.) Specify: work done 16b. Kind of Business/Indu	hite
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu e event, the Medical Exan To Be Completed	17.1 guici 3 ramo (1 mst, rendaro, edet)	substitute teacher	e (First, Middle, Maiden Surname)	unk
21215 Ould be file d Mental Hy s marked o tic event, the TO Be C	Herbert Garrett Sr 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zi	p Code)
ore, MD 2 so 1 and 2 shou of Health and 1 If item 27 is 1 ner traumatic	Jeffrey Garrett/nephew 20a. Method of Disposition 2	Ob. Place of Disposition (Name of cemetery,	Millersville, MD 2 Date 20c. Location - City or Too	Nn, State
Baltimore, permit Pages I an Department of Hee Important: If ite	Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state 21. 1 Greef Funeral Spice Lice Rona State Direct	crematory or other place) 22 Name and Address of Facility COT State Anatomy Boar	d 655 W. Baltimore S	Street
Physician 'Medical kaminer	23a Part I. Enter the dilease, or com lications that caused the difailure. List only one cause on each line. Immediate Cause (Final disease a. Sertraline	eath. Do not enter the mode of dying, such as cardiac and methadone intoxicat		Approximate Interval Between Onset and Death
raminer		ce of):	/00 mm	
760, ficate be executed g physician and site burial - transit	X UNPENDED AMENDED 23a, 2	27,28a-f,perME, g891 5/13		
cath certi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fetal death 3 Ectopic pregi	23d. Date of delivery Month Day	/ Year
, P.O. B ires that the d signed by the lot detached the left by the left by the left by the left by Physical		not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	
Division of Vital Records, tal or Attending Physician: The law requires fire death. "I Director: After this certificate has been sighted in by the funeral director, page 2 should be partification: To Be Commisted.				psy findings available mpletion of cause of
tal Rectant: The certificate rector, page	25. Was case referred to medical	26 Place of Death (Chec 2 ER/Outpatient 3 DOA Other War	k only one) sing Home 5 Residence 6 ✔ Other: S	Scene
ding Physi	1 Ves 2 No Inpatient	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred unk	
Division O' To the Hospital or Attending within 24 hours after death To the Funeral Director: Afte completely filled in by the fune	Pending Investigation 3 Suicide 6 X Could not be determined 4 Homicide 5 Pending Investigation 28e. Place of Injury - (Specify) For	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rura or Town State) 4310 .Jeff Apt 104 Hyattsvill	Route Number, City erson St e, MD
To the Hospital within 24 hours To the Funeral completely filled		owledge, death occurred at the time, date and place, a tion and/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated d at the time, date and place, and due to the	I. cause(s)
To Cor	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mont April 28, 2009	h, Day, Year)
	30. Name and address of person who completed cause of death Ling Li, MD Assistant Medical Examiner			:
Stat	Dog Dogistrario S			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May 6, 6;30 P/ M 2009 Ernest S. Gustaitis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 413 Sacred Heart Lane Reisterstown 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Days Hours 1X M 2 ☐ F Oct.19,1933 Hampstead, Md. Director 217-28-1516 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits show 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Modical Evaminer must be notified at 1 ☐ Yes 2 No Director Md. Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21136 413 Sacred Heart Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1% Yes 2 No If Yes, Give 51/53 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1∐Yes 2**X**∏No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Duron Paint Co Elementary/Secondary (0-12) College (1-4or 5+) High School Sales 7 is marked other traumatic event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be the propert of Health and Mental Anna Polanskas Stanley Gustaitis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. 413 Sacred Heart Lane Reisterstown, Md.21136 Shirley L. Gustaitis Mrs. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/09 Cockeysville, Md. Dulaney Valley Park 22. Name and Address of Facility 21. Signature of Funeral Service Livenses 11824 Reisterstown Road Eline Funeral Home Time Reisterstown, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Imprediate Cause (Final divease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Box 68760,27 Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 1No 1 □Yes 2 🖃 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signat e and title of certifie vX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Contac Street W65HINSTON HD 21157 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day MAY 2009 2:16 P M EVA **GUTHORN** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE OF BALTIMORE TOWSON BALTIMORE 8. Date of Birth 05/13/1913 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1□M 2X F Months Days Hours **POLAND** 95 056-18-3389 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No N/A BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 7301 PARK HEIGHTS AVENUE, #403 USA 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □ Yes 2 🛚 No Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT NON-PROFIT ASSOCIATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BENDIX KIEWE ELFRIEDA VERTUN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LESTER GUTHORN / SON 2302 VELVET VALLEY WAY, OWINGS MILLS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 X Removal from State MAPLE GROVE CEMETERY 05/11/2009 KEW GARDENS, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) LUNA MONTHS Due to (or so consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident

Physician /Medical Examiner Exami

Physician

/Medical

Examiner

Funeral

Director

Items 23a or 28a-f show

Directo

Funeral

Completed

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be filed within 72 hours after death with the Marylar ntal Hygiene.
ed other than "natural", or Items 23a or 28a-f show event, Itm "natural" or it is a notified at

and Mental Hygi

or other traumatic

permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any injury or other trau

signed by the attending physician and be detached for use as the burial-trans

s certificate has birector, page 2 s the Hospital or Attending Physician: neral Director: After this y filled in by the funeral di After this

Division of Vital Records, P.O. Box 68760

9

Medical

Physician/Medical Completed Be 2 Certification:

29a, Certifier

3 ☐ Suicide

4 Thomicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D64395 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUL DOBERMAN. MO 6565 N CHAPLES ST, SUITE 209 BALTIMPE, MD 21204

State Registrar

ORIGINAL

within 24 hours a

To the Funeral D

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death 2. Date of Death 3. Time of Death **Physician** 2:00 /Medical city, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Marginal Eventine must be purified at once. Oity, Town or Location 10d. Inside City Limits State Director 1 ☐ Yes 2 No 10f. Zip Code 100 Street and Nu 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u>Ş</u> 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DC NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Racke 18. Ma r's Name (First, Midel), Be 20b. Place of Disposition (Name of 🕯 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) f Funeral Service Sian*a*ture Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic obstructive pulmonary disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ned by the attending physician detached for use as the buris The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ∃Yes 2⊟No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No certificate 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D63881 8. 2009 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Javillo 2435 what Belvediere Winner, Baltimore, Maryland 21215 MD Jason 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State

Registrar

			For State Registrar	State o	of Marylan	•	artmen rtificate			Mental H	Hygiene Reg. No.	0000	15100
			1. Decedent's Name (First, Middle,	Last)					*****	2. Date of	Death	400	3. Time of Death
	Physicia		Casper E.	Hac	kmann					Month May	Day O 8	2009	11:00 AM
4/10	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location of Dea	ath	4c.	County of Deat	h
			3 Linda Lane					Sev	verna Pa	ark		Anne A	rundel
I	Funeral Director		5. Social Security Number 215-16-7379	6. Sex 1 🖳 M 2 🗆 F	7. Age (In yrs.	last birthday) 36 Yrs.	If Under Months	1 Year Days	If Under 24 Hr Hours Mir	8. Date of (Month) Sept.	Birth Day, Year) 26 1	9. Birtl Co	hplace (State or Foreign untry) MD
	p ,		Usual Residence of Decedent		1.0								40d Inside City Limits
	arylaı shov	<u> </u>	10a. State 10b. County		10c. Cr	ty, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M 28a-f	Director		Arundel			101 7		len Burr	nie	10- 04	izen of What Co	••
	a or ith t		10e. Street and Number	- 7			10f. Zip		21060		10g. Cit	USA	unity:
	is 23	eral	7618 Solley Ro		edent Ever in U	S 13 1	Was Deced			Specify Yes or	r No-	14. Race - Ame	rican Indian
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If tien A? is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanime must be notified at once.	by Funeral	Marital Status Never Married 2 Marrie Widowed 4 □ Divorced	Armed Fo	orces? 2 No ive		f Yes, spec 1 ☐ Yes 2		spanic Origin? on, Mexican, Pue Specify:	rto Rican, etc.)	Black, White	
3	tural		15. Decedent		ales.	16a. Dece	dent's Usua	al Occupa	ation		16b. Ki	ind of Business/	Industry
2	in 72 n "na n "na m "na	Completed	(Specify only highest	grade completed) College (4.4	i (Give		rk done d	uring most of w	orking			
7	d with giene ir tha	E	Elementary/Secondary (0-12)	College (1-401 5+)		Pi	pe F:	itter			Oil Com	ıpany
2	othe vent,	Be	17. Father's Name (First, Middle, L	ast)					18. Mother's Na	ame (First, Mic	ddle, Maiden	Surname)	
9	Ments Ments arked atic e	2	John L.	Hackmann	Sr.				Amolie	a :	Strobe	1	
N N	ind 2 sho alth and 27 is m er traums		19a. Informant's Name/Relationsh Carl Hackmann	ip <i>(Type. Print)</i> (SOI	n)	1	•	,	Severn		-	or Town, State, 2 1146	Zip Code)
ָט ט	es 1 a of He item		20a. Method of Disposition		20b. f	Place of Dispo cemetery, crer	sition (Nan	ne of ther place	e) ! M =	Date	20c. Lo	ocation - City or	Town, State
	Page ment ant: If		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other <i>(Sp</i>		State	tro Cre			inay	2009	Balt	imore,	Maryland
Dall	permit. Departi Import any inj		21. Signature of Funeral Service L	icensee	Min	1) 22			s of Facility Itain Ro	Stalli:	ngs Fu sadena	neral H	ome, P.A. 122
			23a. Part . Enter the disease, r c shoot, or heart failure. List of	complications that	cal lead the Lyat	Do not ent		-	g, such as cardi				Approximate Interval Between
w. F	hysician		Immediate Cause (Final disease or condition	any one oddoo on	CORC	ALA	TV	- 1	ARTS	1503	VI	SEAS	Onset and Death
A	/Medical		resulting in death)	Due to	(or as a conseq	quence of):	10				0 1	021112	
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ָ כ	has be	Completed by									Was an	24b. Were au	utopsy findings available completion of cause of
	Fnysician: The la rithis certificate has ral director, page 2	ĕ								1 DY	performed?	death?	_
2	stan: artific ctor,	Be	25. Was case referred to medical examiner?						26. Place of D				
	nysic this o	၉	1 ☐ Yes 2 TNo		Inpatient 2				4 LI Nursing	Home 5□ F	Residence	6 Other (Spe	city) RESIDENCE
	After 1	ë o	27. Manner of eath Natural 5 Pending	28a. Date (Mor	of Injury oth, Day, Year)	28b. Time o Injury		8c. Injury Work		28d. Descr	ribe how injur	ry occurred	, , , , , , , ,
2	tend leath. tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could no	ot be			М		res 2 □ No				
	or An	Certification:	4 ☐ Homicide determin	28e. Place	e of Injury - At h ling, etc. <i>(Speci</i>	iome, tarm, str ify)	eet, factory	, office		City or	on (Street ar r Town, State	nd Number or Hu e)	ural Route Number,
	ours and lear all filled		29a. Certifier Certifying	Physician: To th	e best of my kn	owledge deat	h occurred	at the tin	ne, date and pla	ace, and due to	the cause(s	and manner a	s stated.
0	To the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		xaminer: On the									
ŀ	To To I	Σ	29b. Signature and title of certifier	0<	-//		290	c. License	number	10	29d. Da	ite signed (Mont	h, Day, Year)
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			30. Name and address of person v	E FISH	1812	CRA	rint)	Ton	ENS	GLEN	1 BV	RNIE	21060
	Sta Registr		31. Date filed (Month, Day, Year)	100	Registrar's Sign	ature	Ked.						
	riegisti	uı	MAITEC	WI DEW	un p	· jejun	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 5:40 A.M Earl Monroe Harmon 2009 May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign Country) Kentucky If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9/24/1920 6. Sex, 125M 2□ F 5. Social Securify Number 7. Age (In yrs. last birthday) Hours Davs Months 88 402-12-6443 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County Baltimore Pikesville Maryland 1 ☐ Yes 2 ☐ No 10g Citizen of What Country? United States of America 10f. Zip Code 10e. Street and Number 21208 3226 Marnat Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2 □ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 → Married Specify: White If Yes, Give Year or Dates 1 ☐ Yes 🏋 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pennsylvania College (1-4or 5+) Railroad Freight Conductor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Harmon Katherine Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Minnie F. Harmon/ wife 3226 Marnat Road Pikesville, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20c. Location - City or Town, State 20a. Method of Disposition May 10, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Relair Fundam Service 21. Signatur 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P. A. Timonium, Maryland 21093 2325 York Road 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WICKS STROKE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice

Physician /Medical Examiner

permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Physician/Medical

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Be Completed

Certification: To

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "kedical Examinar mast be reaffled at

and attending physician the nse signed by page 2 should een has certificate funeral director, After this

he law requires that the death certificate be executed

or Attending Physician:

To the Hospital

death.

within 24 hours after death

To the Funeral Director:

the

filled in by

completely

Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 📆 No 27. Manner of Death

5 Pending

6 Could not be determined

1)XI Natural

3 Suicide

2 ER/Outpatient 3 DOA 1 Inpatient Date of Injury (Month, Day, Year) 28b. Time of investigation

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29b. Signature and title of certifier

58303

31. Date filed (Month, Day, State Registrar

Year)

MARIES

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 10, May 2009 Charles A. Hennrich 1:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Marley Neck Health & Rehabilitation Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)

New York 7. Age (In yrs. last birthday) Funeral 1**X** M 2□ F Months Days Hours Min. 092-24-3836 Director 79 NOV 6, 1929 Usual Residence of Decedent 10b. County 10d. Inside City Limits show 10a, State 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Mydical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 Beach Road 21122 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ≥ Specify: 3 Divorced 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Poultry Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Hennrich မ Mathes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Beach Road Pasadena, MD 21122 Mary Ann Wood, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 05/11/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 190 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami and burial-trai Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the detached 9 Unknown 9 Unknown þ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? has certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ this funeral 27. Manner of Death 1 Natural ne Hospital or Attending Pl n 24 hours after death. he Funeral Director: After t pletely filled in by the funera 28a. Date of Injury (Month, Day, Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and of certifier D57028 May 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra, M.D. 600 Ridgely Avenue, Suite 231 Annapolis, MD 21401 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 1 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1300 M RED ERICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 216 Henson Road Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year)
Feb. 27,1945 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 2 M 2 □ F 330-76-7632 64 Director Usual Residence of Decedent d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Henson Road 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) (level) Dependent Providence, Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Hake traumatic ပ Beatrice Hemman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan Weisgerber/Advocate 931 Spa Road Annapolis, MD 21401 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other i once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date May 15, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2009 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Servcies PA 1 2nd Ave.SW Glen Burnie, MD 21061 Approximate 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live birth 2 Fetal death õ in the past 12 months? Month Year Pregnant at time of death 1 ☐Yes 2 ☐No detached 9 Unknown is been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 No 1 🗌 Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural 5 Pending Injury death. 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 11,2009 who completed cause of death (Item 23a) (Type, Print) Name and address of pers 441 MGHWAM HAEL 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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		1 - For State Registrar	Í		Certificate of			Reg. No	2000	15202		
Physici	an	1. Decedent's Name (First, Middle, Last) Fahule Holde					2. Date of De Month	Da		3. Time of Death.		
/Medic		4a. Facility Name (If not institution, give str			4b. City, Town,	or Location of Deatl	04	Z 4c.	County of Deat			
Examin	lei	University of Maryale	1 1 0	and	- Balti	more			N/A			
Funeral		5. Social Security Number 6. Sex 227 – 20 – 9756	7. Age (In yrs. i		day) If Under 1 Year Months Days		(Month, Da	ay, Ye <i>ar)</i>	Co	hplace (State or Foreign untry)		
Director		Usual Residence of Decedent	88				JULY	7,19	720]_V1	rginia		
arylan show	<u>_</u>	10a. State 10b. County	10c. City	y, Town	or Location					10d. Inside City Limits 1 ☑Yes 2 ☐ No		
the M	rect	Maryland N/A 10e. Street and Number	Bal	Ltin	nore			10q. Cit	tizen of What Co			
th with 23a or	Funeral Director	3000 Towanda Ave	nue Apt. 21	13	2121	5	ţ	JSA				
tems	nue	Tr. Marital Otatas	2. Was Decedent Ever in U. Armed Forces?	S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	D-	14. Race - Ame Black, White			
irs afte	þ	1 ☐ Never Married 2 ☐ Married ☐ 3X Widowed 4 ☐ Divorced	1 ∐Yes 2y∑No If Yes, Give Year or Dates:		1 □ Yes 2 🙀 No	Specify:			Specify Bla	ıck		
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s 1 and of Heal item 2 other		20a. Method of Disposition	20b. P	lace of D	Disposition (Name of crematory or other pla		Date		ocation - City or			
Page ment c ant: If ury or		1 Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)			Memorial		9/09	WOOG	dlawn,	Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it w. M. deal Examinar rust be rotified at once.		21. Signature of Funeral Septice Licensee			22. Name and Addr	ress of Facility Ch	atman-	Harr	ris Fur	neralHome		
		5240 Reisterstown Road Baltimore, Md 212 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line interval Between Onset and Death Approximate Interval Between Onset and Death										
Physician	٠.	shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	is	LPNA					Onset and Death		
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th cert tending r use a	M/ue	23b. was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		3 ☐ Ectopic pregnar	ncv			23d. Date of de	,		
ne dea the att hed fo	/sicia	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4 Pregnant at time of d		5 Other (specify)	ioy			Month	Day Year		
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	ledical C		cian: To the best of my knoer: On the basis of examina and manner stated.									
To the within to the comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Da	ate signed (Mon	th, Day, Year)		
		1560	MD		158	88238	27	4/	29/0	9		
M		30. Name and address of person who com	pleted cause of death (Item 22562	23a) (T	ype, Print) 5+ Bal	tim	MT	7 /	201			
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		- (Bac	102			201			
Registr	ar	MAY 1 2 2009	Cenera S.	100	ales							

DHMH 17 Rev 1/2001

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** Rosalie Hite /Medical Examiner 5. Social Security Number **Funeral** Director 217-56-8059 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County ral", or items 23a or 28a-f show Director MD 10e. Street and Number Funeral 11. Marital Status Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced "natural" Completed within Lygiene. 7.27 is marked other than "n traumatic event". Elementary/Secondary (0-12) 8 Be ၉ Cletus Hite of Health a Department of Health Important: If item 27 any injury or other tr

4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Dundalk Baltimore 3136 Baybriar Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🛛 F 57 3-5-1952 MD 10c. City. Town or Location 10d. Inside City Limits 1 TyYes 2 □ No Dundalk Baltimore 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3136 Baybriar Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐Xlo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Audrey Bohrer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3136 Baybriar Road, Dundalk, MD 21222 Robert L. Hite, Sr.-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 5-12-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final astalle 2 MONTY disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for es a consequence of Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ❷ No 24a Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

9

2009

Month

May

3. Time of Death

10:30A

Examiner ires that the death certificate be executed the burial-transi P.O. Box 68760. signed by the a

3altimore,

Physician

/Medical

DIVISION OF VITAL RECOF
To the Hospital or Attending Physician: The law req
within 24 hours after death.
To the Funeral Director: After this certificate has been
completely filled in by the funeral director page 2 shoul

State

Registrar

29a, Certifier

(Check only one)

29b. Signature and title-of certifier

31. Date filed (Month, Day, Year)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

will

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) turio 11

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # 6 per FH G891 5/2//09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 11:15 AM 2009 MAY HARRIS KATIE 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner JOHNS HOPKINS HOSFITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Hours Months Davs 1∭2M 2**X** F 234-32-7681 12-23-1924 WV Director 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State 28a-f shov traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 □ No Director Baltimore City MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō death with 21224 USA 23a 405 S. Macon Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. items permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, Its Medical Exercit 1 Tes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No 1 ☐ Yes 2 No Specify Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Police 2+ Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lemonia Plakitsis Spiros Papandreas ည 19a. Informant's Name/Relationship (Type. Print)
Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8344 Analee Ave., Baltimore, MD 21237 <u> Marcella Harris Lambros</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Daurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 5-13-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ALUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): attending physician for use as the buria pe Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
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9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 □ Yes 2 🗷 No 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tohacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed The certificate 2 🗷 No 1 □Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 M Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a t 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

completely To the I within 2. State

3altimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Registrar

31. Date filed (Month, Day, Year) 2 2009

OSTRIN

29b. Signature and title of certifie

FOWIN

JOHNS 32. Registrar's Signature

and manner stated.

MD 30. Name address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-

000

29d. Date signed (Month, Day, Year)

MAY

ins Hospital, Wolfest. Baltimore, MD

2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** April 25, 3:00 PM M Ralph H. Hamilton Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's 203 Deer Run Lane Stevensville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral 1 ₹ M 2 □ F 182-24-9089 Director Aug 1, 1931 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shov MD Queen Anne's 1 ☐ Yes 2√ No Stevensville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number iral", or Items 23a or Examiner must be 203 Deer Run Lane 21666 Funeral USA death Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Iten any or other traumatic event, the Medical Examinatory or other traumatic event, the Medical Examinatory. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: white Yes. Give Completed by 3 Widowed 4 Divorced Year or Dates: \$52-54 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 plumber maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William John Hamilton Edith E. Phipps ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia Hamilton/spouse 203 Deer Run Lane Stevensville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature | Funeral | nvice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit ANGMIA Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year signed by the a 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐Yes 2 No vurs after death.

eral Director; After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00027055 5-5-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Joel H. Wilkerson,M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

204 Medical Center Rd. Grasonville, Md. 21638

09-03601 Judith Sandra Hardy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Juit	ii ou iu iu i		- For State	Certif	ficate of D	eath		Reg.	No.	
	Physicia		tegistrar 1. Decedent's Name (First, Middle,Last)					Date of Death Month Date	ay Year	3. Time of Death 0335 hrs
Иjer	ical Exami		Judith Sandra Hardy	7			C (David	Month Day 5, 2009	4c. County of Dea	
			4a. Facility Name (if not institution, give stre	et and number)		City, Town, or Lo	ocation of Death		Baltimore Co	
			343 Stillwater Road			ssex	If Under 24Hrs	P. Data of Birth/		Birthplace (State or
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		f Under 1 Year Months Days	Hours Min		For	eign
	Director		212-84-1878 1 M	2 X F 48	Yrs.			07/30/	1960	CountryMaryland
			Usual Residence of Decedent	Idoa City To	own or Location					10d. Inside City Limits
	w any		10a. State 10b. County							1 Yes 2X No
	Aaryland 28a-f show 1 at once.	ē	Maryland Baltimore	Essex		0f. Zip Code		100	Citizen of What C	ountry?
	Mary - 28a-ed at	ec.	10e. Street and Number			·		1		
9	h the 23a ou	Ö	343 Stillwater Road		142 1/40 5	21221	anic Origin? (S	pecify Yes or No-	nited Sta	nerican Indian, Black,
0/1/0	death with the Maryland or items 23a or 28a-f shoomst be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 X Married	. Was Decedent Ever in U.S. Armed Forces?	If Yes	specify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc	
1	r dea	μ		Yes 2 X No	1 T Y	es 2 X No	specify:		Specify: V	White
	rs afte	by	Widowed 4 Divorced of or 15. Decedent's Education (Specify only h	lates:	6a. Decedent's	Usual Occupation	on (Give kind of	work done 1	6b. Kind of Busine	ss/Industry
	2 hour "natr	ted		College (1-4 or 5+)	during most	of working life.	DO NOT use ret	ired)		
	hin 7. e. than	βldι	12		Homemal			Ĺ	Domestic	2
	d with year of the M.	Completed	17. Father's Name (First, Middle, Last)			1	8.Mother's Nam	e (First, Middle, Ma	iden Surname)	
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be (Walter Zebrowski				Rose Lo	siewski		
	ould It Mer s mar	P.	19a. Informant's Name/Relationship (Type		1			Rural Route Numb		1
	MD and 2 sho alth and m 27 is aumati		Glenn W. Hardy, Jr.	Husband		illwatei on (Name of cem		Essex, Ma	ryLand Z 20c. Location - City	v or Town, State
	imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours at ment of Health and Mental Hygiene. Itani: If item 27 is marked other than "natural or other tranmatic event, the Medical Examin		20a. Method of Disposition 1 X Burial 2 Cremation 3		ematory or othe	r place)	ictory,	Build		,
	Page Page nent o		4 Donation 5 Other Specify:		y Rosar	y Cemete				re, Maryland
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera II the Things of the Triem 23 a marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once,		21 Signature of Funeral Service Licensee		Dav	me and Address id J. We	of Facility eber Fur	neral Hom	es P.A.	
			23a Part I. Enter the disease or complica	U W-t council the death.	401	S. Ches	<u>ster Str</u>	cet Balt	imore, Ma it, shock, or heart	Approximate Interval
	Physician 'Madical		failure. List only one cause on each	me.			30011 00 0010100	o, 100p.1010.)	, ,	Between Onset and Death
	ramine			entanyl intox e to (or as a consequence of)						
			h	to (or as a consequence or)	•					
		ē		e to (or as a consequence of)	:					
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence of)		1277				
1	msi ee 👌	X	events resutting in death) Last	,						
1	760, icate be executed physician and the burial - transit	Medical	X UNPENDED A	MENDED 23a,27,2	28a−f,pe	rME, g8	91 5/19	/09 TT		
	60, ate be shysicial to burish	led		23c. If yes, outcome of pregn	ancy				23d. Date of de	livery
	1876 rtifica ing ph	[23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	al death 3	Ectopic preg	nancy	Month	Day Year
	Box 6876(e death certificate the attending physel for use as the b	<u>i</u>	No. of No. of Malanus	4 Pregnant at time of dea	oth 5 Oth	er (Specify)				
	Records, P.O. Box 687 The law requires that the death certific teare has been signed by the attending I nave 2 should be detached for use as I	Physician	Part II. Other significant conditions	g Unknown	sulting in the ur	deriving cause of	given in Part I.	23e. Did tol	acco use contribu	te to the cause of death?
	D.O. that t	þ	Part II. Other significant conditions	manufacture to bodan bot motion		, 5	•	1 Yes	2 No 3	Probably 4 V Unknown
	S, F quires en sig	te						24a. Was a		re autopsy findings available
	Orc aw re tas be	Completed						autops perfor	m <u>ed</u> ? dea	or to completion of cause of ath?
	Rec The I cate began	5						1 ✔ Yes	No 1	Yes 2 No
	tal Reco	l a	25. Was case referred to medical examiner?	pital:			Other Nur		Residence 6	Other: Scene
	of Vit ing Physic After this	=	1 ✓ Yes 2 No	T	ER/Outpatient 28b. Time of In		ary at Work?		low injury occurred	
	Jor Jing F	=	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)			Yes 2 X No	unk		
	ivisior I or Attendather death Director:	ja ja	2 Accident Pending Investigation	Fd 5/5/09 28e. Place of Injury - At ho	Fd 3:0	Jamp —		28f Location (S	treet and Number	or Rural Route Number, City
	Division of Vital Records, P.O. pital or Attending Physician: The law requires that towns after death. each Director: After this certificate has been signed by filled in by the fineral director maye? Should be detacted in by the fineral director maye?	Certification:	3 Suicide 6 X Could not be determined		sidence	t, lactory, cilico	bananig, oto	or Town, S Essex,	tate)343 St	illwater RD
A 3	ie Spi		4 Homicide	. To the best of my knowledge	ne death occur	ed at the time d	late and place, a	and due to the caus	e(s) and manner a	s stated.
X	To the Hos within 24 lb To the Fu	Medical	one) 2 Medical Examiner: C	n the basis of examination a	nd/or investigati	on, in my opinio	n, death occurre	d at the time, date	and place, and due	e to the cause(s)
pan	To To	Med	29b. Signature and title of certifier	nd manner stated.		29c. Licen				(Month, Day, Year)
			(b)	LAID DOLV		0.0	.M.E.		May 5, 2009	
			30. Name and address of person who co	mpleted cause of death (Item	23a)					
				Medical Examiner	111 Penn S	Street, Baltim	nore, MD 21	201		
		State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	bark.	1				
		stra		Deneur p.	19 ans					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Frank S. Hubbard Mav 2009 2050 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 X M 2 □ F Director 88 577**–**20–5001 January 14, 1921 Georgia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm McIIcal Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? death with 3206 Weller Road 20906 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Affiled Folces: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Photographer 12 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank S. Hubbard ဂ Marguerite Fields 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Helen A. Hubbard / Wife 3206 Weller Road, Silver Spring, Maryland 20906 other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 cemetery, crematory or other place)
Parklawn Memorial Park
Mausoleum permit. Pages Department of Important; If it any Injury or o May 11. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify)Entombment 2009 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee ~M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiogenic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Non-ST Elevation Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attending Physician: The law requires that the death certificate be executed Atrial Fibrillation attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Respiratory Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a Was an certificate 1 ☐ Yes 2 🕅 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💹 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.0. Division of Vital Records,

altimore, Maryland 21215-0036

Hospital or

State

within 2

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahamanian Shahri,

-avia

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D66372

29d. Date signed (Month, Day, Year)

May 8, 2009

M.D. 7500 Hanover Parkway Suite101, Greenbelt, Maryland 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #3, perMD & 10e,18 & 19b, perFH 8891 57,22/09pins Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death AM 2:00 PM 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5, 2009 Oliver Tan Hieu Ha /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex 1 X M 2 □ F **Funeral** Hours Min. Days Months Yrs. June 29, 32 Director France 212**-**11-6142 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Ferrara United States 4016 20906 Funeral Farrara Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 2 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 College (1-4or 5+) Elementary/Secondary (0-12) Federal Express 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be f th and Mental I Thoa Thi Ngoc Duong Thoa Suzanne ပ Tan Hieu Ha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 4016 Farrara Drive, Silver Spring, Maryland 20906 Tan Hieu Ha/ Father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State orium Inc. 18, 2009 | Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 May 8, 2009 4 ☐ Donation 5 ☐ Other (Specify) Crematorium Inc. 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Liver Adenocarcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the damps of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, Maryland 20850 Rohatgi, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 2 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🧎 🤍 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 2:35 PM Sylvia Harrison Mav 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Randallstown, Baltimore Mary land Northwest Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 □ M 2 🗙 F 215-10-7868 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, its Involction is saminer must be notified at 1 ☐ Yes 2 No Director BALTIMORE REISTERSTOWN MD 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number 21136 USA 12020 REISTERSTOWN ROAD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: WHITE Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME **HOMEMAKER** permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other t any Injury or other traumatic event, II. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **FANNIE** NORAN NEEDLEMAN BORIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5333 NICKLAUS DRIVE, WINTER HAVEN, FL DAVID HARRISON / SON 20b. Place of Disposition (Name of Pages 1 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 05/10/2009 FINSKBURG, MD BETH JACOB CONG 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS. INC. 22. Name and Address of Facility 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed the burial-trans CAD and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical [BirtA Fibrillott attending ph for use as the IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Ducroler, cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Worknown SEISULE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Demention certificate has autopsy 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Teath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 ☐ Accident 5 Pending Not Applied ble M | 1E 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attenc within 24 hours after death To the Funeral Director: Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide der lifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Ekaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an 7,2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronclalls tails, MD 21133 Rupesh Vakil 5401 old Gurt Road

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

09-03685 Martin David Hvatt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 | 5210

Martin David Hyat	1-	For State	tate of Mi	al ylalla /	Certific	cate of	Death					Reg. No			3. Time of I	Dooth
Physiciar	_	distrar Decedent's Name (First, Mid	dle,Last)							1 -	Date of De Month	Day	Year		1920 h	
Medical Examin	er	MARTIN HYATT 4a. Facility Name (if not institution, give street and number)				[4	4b. City, Town, or Location of Death				May 7, 2009 4c. County of Death					
	4	a. Facility Name (if not instituted) 40 S. Ritters Lane	ion, give street	and number/			Owings				8. Date of Birth (MW/DD/YYY				-	te or
Funeral	5	. Social Security Number	6. Sex	7. Age	e (In yrs. last b	irthday)	If Under Months		If Under Hours	1.0				i – oreidi	n untry) M	
Director	2	13-70-6546	1 X M 2	F	43	Yrs.	Monare				05/24	/ 190	00			
× .	_	Sual Residence of Decedent 0a. State 10b. Count	v		10c. City, Tov											e City Limits
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aryland Ba-f sh	Director	0e. Street and Number					10f. Zip (-	10g. C	itizen of Wh		ntry?	
the Ma a or 2	ắþ	O SOUTH RITTERS LANE					21117 13. Was Decedent of Hispanic Origin? (Specify				cify Yes or	No-	US/		ican Indian	, Black,
h with	Funeral	Marital Status Never Married 2		rmed Forces'		13. Wa	es, specify	Cuban,	Mexican,	Puerto R	tican, etc.)			e, etc.		
er deatl	되		1 Divorced of Yes,	Yes 2 Give Yeer	X No		Yes 2						Specify:		WHITE	
urs afte	-[호	15. Decedent's Education (S	l or Dat	BS'	mpleted) 16	Sa. Deceder	nt's Usual (nost of work	Occupation	on (Give k	kind of wo	ork done ed)	16	b. Kind of B	usiness/	Industry	
5 72 hoi nn "na cal Ex	Completed	Elementary/Secondary (0-	(2) C	ollege (1-4 or	5+)		ALES						COMMUI	NICA	TION	
5-0036 fled within 7 Hygiene. I other than	E L	17. Father's Name (First, Mid	dle Last)	4			ALES		8.Mother	's Name	First, Midd		en Surnam			
115-1 e filed al Hyg ced oth	Be C	SAMUEL	НҮАТ	Т	_			F	ROSAL	.IE		N	ENGL	ANDE	R Zin Code	9)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportunit: If filene 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ᆰ	19a. Informant's Name/Relati											r, City or To			-,
MD nd 2 sho afth and m 27 is	1	DIANE HYATT/F 20a. Method of Disposition			20b. Pla	ce of Dispo	OUIRE sition (Nar	ne of cer	netery,		Date	2	0c. Location	- City o	r Town, Sta	ate
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Crema	ation 3 Re	emoval from S	State BALT	HMORE	ther place	JEW (CONG.	05/	11/20	200	BALTI	MORE	E,MD_	
tin Pag rtment ortant:	-	4 Donation 5 Othe 21. Signature of Funeral Ser			Unix	22.	Name and	Address	or Facility	ySOL	LEVI	VSON	& BR	OS.,	, INC	•
Ba perm Depa Impo injur		17 . 1	- /		2	89	00 RI	ISI	ERST	NWC	ROAD,	PIKE v arrest	SVIII	E N	, ppio	Milliaco III.
Physician	í	23a, Part I, Enter the disease failure. List only one ca	e, or complication ause on each lin	ons that cause e.	ed the death. L	o not enter	the mode	d Abdr	man	odi di do o	, , , , , , , , , , , , , , , , , , , ,	, .			Betwe	een Onset and Death
/Medical aminer		Immediate Cause (Final disc or condition resulting in dea	ease a. Con	tact Guns	hpt Wpund	s (2) DT F	nead an	d Abul	Jillell							
		Sequentially list conditions,	b											_	+-	
	iner	if any, leading to immediate cause. Enter Underlying Ca	ause		nsequence of):											
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m ge in	Medical	IF FEMALE:			tcome of pregn	ancy							23d. Date Month		very Day	Year
5876 ertifica ding ph	an/N	23b. Was decedent pregnan past 12 months?	1	Live birth	n It at time of dea	=	Fetal death		Ectop	pic pregn	ancy		Wicht	'	,	
Box 687 death certific the attending ped for use as the	Physician/	1 Yes 2 No 9		Unknowr	n						1000	Distant	2000 USB 66	ontribute	to the cau	se of death?
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tal Rec rian: The la certificate h	Completed							26.Pla	ce of Dea	th (Chec	k only one					
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of Vital Recing Physician: The After this certificate fineral director, page	2	27 Manner of Death	0	28a. Date of	f Injury Day,Yaar)	28b. Time FOUND:			yes 2		28d. De Subjec	scribe h ct shot	ow injury od self	currea		
Ion (tendin eath.	ation	1 Natural 5	Pending Investigation	May 7 20	กกด	1914 hrs		-			28f. Loc	ation (S	Street and N	umber c	r Rural Ro	ute Number, Cit
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physmomenical tilled in the fineral director page 2 should be detached for use as the b	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 40 41 41 42 42 44						or Town, State) 40 S. Ritters Lane, Owings Mills, MD								
Ospital hours								the time	, date and	i place, a	nd due to t	he caus	e(s) and ma	nner as	stated.	se(s)
thin 24	Medical	Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)														
J F S F S	2	29b. Signature and title of	certifier /	a a ()		į		ense numb C.M.E.	ber			May 8,			
		aide	- Ht	ll	a of death (Item	n 23a)							L			
		30. Name and address of Carol Allan, MD	person who cor Assistant	npieted cause Medical E	Examiner	111 Pei	nn Stree	et, Balt	imbre, l	MD 21	201					
	Stat	S4 Date filed (Month Day			gistrar's Signat	ure	1	9								
Reg	istra	MAY	1 2 2009) Con	way	T. /T	arke									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 May 8, Margaret Coolahan Ijams 1:00 AM 4a. Facility Name (It not institution)
5534 Willys Avenue Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arbutus Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 XF 67 1941 Maryland 220-38-7005 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 XNo Baltimore Arbutus 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5534 Willys Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant **Healthcare** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Coolahan Blanche Zimmerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William S. Ijams - Husband 5534 Willys Avenue, Arbutus, MD 21227 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 5-12-2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Sign ture of Fun Service License 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST METASTATIC 15 YEARS Due to (or as a consequence of) Sequentially list conditions, if any leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsisquinnia of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2. No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XINo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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MD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It whe died Examiner invest be notified at

3altimore, Maryland 21215-0036

/Medical

burial-trar attending physician for use as the buria as nse for sate has been signed by the page 2 should be detached certificate

Division of Vital Records, P.O. Box 68760,

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To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certificat Medical

1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

29b. Signature and title of cartifier

5 Pending investigation 6 ☐ Could not be determined

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

completed cause of death (Item 23a) (Type, Print)

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HOULTON 1 2 31. Date filed (Month, Day,

, SUITE DOY, CATOUSULE, MO 405 FREDERICK ROM Registrar's Signatu una

State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6, 2009 9:20 P May Everene Cooper Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours 1 □ M 2 🖫 F Director 579-52-9596 68 July 13,1940 DC Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 9709 E. Light Dr. 20903 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 😿 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) D.C. Government 5+Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be finent of Health and Mental I Inez Wynn Everett L. Cooper ဂ္ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trauonce. Eugene R. Johnson/Son 10105 Preakness Dr., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State | May 13,2009 Brentwood, MD Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ft. Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a sch line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Year Day Month Pregnant at time of death 5 Other (specify) Ö should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

State

of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

09-03384								
Desires	Johnson							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

esiree Johnson		For State Certificat	te of Death	Reg. No. 2009 1521
Physician/		edistrar . Decedent's Name (First, Middle,Last)	2. Date of De Month April 27,	
ledical Examine	r	Desiree Johnson	April 27,	, 2009 4c. County of Death
	4:	a. Facility Name (if not institution, give street and number) 1210 Ensor Street	Baltimore	Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director			Months Days Hours Min.	2, 1966 Country)
ow any	_	Usual Residence of Decedent 10c. City, Town or	r Location imore	10d. Inside City Limits 1 X Yes 2 No
ine Maryland or 28a-f show		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country? USA
death with the Maryland or items 23a or 28a-f sho must be notified at once.		Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black,
2) 7 Constants after death with the Maryland n "natural", or items 23a or 28a-f sheal Examiner must be notified at once letted by Elimeral Director		1 Yes 2 X No If Yes 2 X No If Yes (Sive Year or Dates:	1 Yes 2 No specify:	Specify: black nk 16b. Kind of Business/Industry unk
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	nai-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk Unk	pecedent's usual Occupation (Give kind of Work or logic luring most of working life. DO NOT use retired)	iik uiik
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than it event, the Medica		17. Father's Name (First, Middle, Last)	unk 18.Mother's Name (First, Midd	die, Maiden Surname) unk
2121 uld be fil Mental I marked c event,		19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)
MD nd 2 sho alth and m 27 is		20a. Method of Disposition 20b. Place of	11 Penn Street Baltimore, of Disposition (Name of cemetery, ory or other place) Date	MD 21201 20c. Location - City or Town, State
를 드로드 하		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state		
Baltimo permit. Page Department of Important:		21. Squatore of Funeral Septine Licensee Licensee Licensee Director 23a. Part I. Enter the disease, of complications that caused the death. Do no	22 Name and Address of Facility State Anatomy Board 655 Baltimore MD 21201	W. Baltimore Street varrest, shock, or heart Approximate Interval
Physician 'Medical aminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (morphi	ine) intoxication and coc	
ammer		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated (Disease or inj		
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certificate be executed adding physician and sas the burial - transition	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery Month Day Year
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be ura siter death. reral Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burn	Physician/	past 12 months?	5 Other (Specify)	_
P.O. B. that the d	হ	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Records, P.O. Box The law requires that the death ceate has been signed by the atte page 2 should be detached for u	Completed			Was an autopsy findings available prior to completion of cause of death?
Rec The la icate h	틼		1 ✓ 26.Place of Death (Check only one)	Yes 2 No 1 ✓ Yes 2 No
ician: s certif	B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Other; Nursing Home	5 Residence 6 Other: Scene
ing Phys After thi	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b.	1 Yes 2 X No	scribe how injury occurred
Division of Vital Records, P.O. to the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact.	Certification:	2 Accident Investigation Accident Suicide 6 X Could not be 1 28e. Place of Injury - At home, from the 1 28e. Place of Injury - At home, from the 1 28e. Place of Injury - At home, from the 1 28e. Place of Injury - At home, from the 1 28e.	11:00 atn farm, street, factory, office building, etc. use 28f. Loca	ation (Street and Number or Rural Route Number, City own, State) 1210 Ensor St. timore, MD
8 - = >		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only	each convirad at the time date and place, and due to th	ue cause(s) and manner as stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	_	anet Z	O.C.M.E.	April 28, 2009
		/ (IId T (db) o III)	Penn Street, Baltimore, MD 21201	
St: Regist	ate		bases	
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			For State of Mai	•	ent of Health and I ate of Death		giene Reg. No.	9 15216	
			Decedent's Name (First, Middle, Last)			2. Date of De	ath	3. Time of Death	
	Physici /Medio		John Willie Tacks	en Tr.		Month	Day Ye		
and the second	Examir Funeral Director	er	4a. Facility Name (If not institution, give street and number) 13	4b. Ci 2ndd Cayse (In yrs. last birthday) Yrs. 4b. Ci Huns Month	der 1 Year If Under 24 Hrs.		v. Year)	1	
			Usual Residence of Decedent			000 20,			
	show	_	10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits 1√2 Yes 2 □ No	
	the Marylar 28a-f show	ecto	MD	Baltimore	7:- 0 - 1 -		10g. Citizen of Wha	21	
	a or 2	흐	10e. Street and Number 11 W. 20th Street lsr flr	Tor.	Zip Code 21218		USA	Country :	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanther rout be neathed at	by Funeral Director	11. Marital Status 12. Was Decedent Ev Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Yas 2 No If Yes, Give		cedent of Hispanic Origin? (S specify Cuban, Mexican, Puert 2 X No Specify:	pecify Yes or No o Rican, etc.)	14. Race - A Black, V Specify:	American Indian, /hite, etc. black	
21215-0036	within 72 hour iene. Than "natural ine Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+)	life. DO NOT	work done during most of wor	unk king	16b. Kind of Busin	ess/Industry uni	
	ould be filed v Mental Hygid arked other i atic event, it	Be	17. Father's Name (First, Middle, Last)	u	nk 18. Mother's Nan	ne (First, Middle,	Maiden Surname)	unk	
Maryland	and Mer Is marke	ု	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Addre	ess (Street and Number or Ru	ıral Route Numb	er, City or Town, Sta	te, Zip Code)	
	1 and 2 Health a em 27 le		Baltimore Rehab Extended CA	,	h Raven Blvd			218	
altimore,	g = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 🖫 Other (Specify) in state	20b. Place of Disposition (for cemetery, crematory of	Name of prother place)	Date	20c. Location - City	or Town, State	
Balt	permit. Pa Departmer Important: any Injury once.		21. Signature of Edineral Services Idensee Rolland S. Wade Dire		and Address of Facility Anatomy Board more, MD 2120		Baltimor	e Street	
	Physician /Medical Examiner		resulting in death)	the death. Do not enter the not. Tive Hoart consequence of):		c or respiratory a	rrest,	Approximate Interval Between Onset and Death	
8760, icate be executed	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
68760,	ate be hysicia the bu	edical	d						
of Vital Records, P.O. Box 68 Physician: The law requires that the death certifica	at the death certific by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of the pregnant at the pregnant	Fetal death 3 Ectop	ic pregnancy (specify)		23d. Date o Month	f delivery Day Year	
rds, P.	quires that t in signed by uld be detad	þ	Part II. Other significant conditions contributing to death but	ng cause given in Part I.			use contribute to the cause of death?		
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Vital	sician: T certificat rector, pa	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othor	ath (Check only			
n of \	ding Phys h. After this funeral dii	on: To	1 ☐ Yes 2 ☐ No Troublish 1 ☐ Inpatien 27. Manuer of Death 1 ☐ Natural 5 ☐ Pending (Month, Day,	t 2 ER/Outpatient 3 Vear) 28b. Time of Injury	28c. Injury at Work?		idence 6 ☐Other how injury occurred	(Specify)	
Division	Attender deatl	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	28f. Location (City or To	18f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or investigated	tion, in my opinion, death occ	urred at the time	, date and place, and	I due to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (/	Month, Day, Year)	
			John & Cala mo	,	34359 (64	10)	5200	7	
			30. Name and address of person who completed cause of deal of the state of the stat	ath (Item 23a) (Type, Print)	and Bolt	o Mar	aland 2	1108	
	Sta Registi		31. Date filed (Month, Day, Year) 22. Registrar	's Signature	29c. License number 34359 (6H wand, Baftimer	0	F(W-C)	/	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9 **Physician** 10.30 AM 09 Edward Joseph Kane /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 05/12/1935 Birthplace (State or Foreign Country) (In yrs. last birthday) Year **Funeral** Days Min 1**X** M 2□ F 73 217-30-4468 Baltimore, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21213 U.S.A. 3450 Cardenas Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. $kane\ Eduo$ Maryland 21215-0036 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Printing Company Elementary/Secondary (0-12) College (1-4or 5+) Printer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Margaret Heuttner Francis Joseph Kane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,2\,1236\,$ 19a. Informant's Name/Relationship (Type. Print) Mary Heward/ Sister 4008 Silver Spring Rd. Apt.1A Baltimore, MD Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Evenster community of the place)

Evens Funeral

Chapel Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/12/09 Forest Hill, MD4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Evans Funeral and Cremation 8800 Harford Rd. Parkville, 21. Signature of Funegal Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final dise or condition resulting in death) **Physician** CHOLANGITI /Medical Due to (or as a consequence of): Examiner SMALL BOWEL OBSTRUCTION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Box 68760, physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes ₽ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has performed certificate I 2 No 1 Tyes kidn disease 1□ Yes 2□No hronic Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1⊿Natural 2□ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 2 2009 L



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SA7ED KA21, S601 LOCH RAVEN BLUD, BALTIMORE

Mn.

es 000

21239

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death ^{Day}2009 **Physician** Month MAY 5 3:41 P M VERA MARIA KLAUS-KOVTUN /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH **BETHESDA** MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, August 15, 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 F Hours 579-68-3335 64 1944 Director Czechoslovakia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Exant har must be notified at Director 1X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 Cathedral Avenue NW, Apt. 211A 20016 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 **X** No 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No ò Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Biologist Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Karel Klaus ည Marie Kvapilova 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trauonce. George J. Kovtun/Husband 3900 Cathedral Avenue NW, Apt. 211A Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 10 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland permit. of Funeral Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature Licensee M01546 7557 Wisconsin Avenue Bethesda, Maryland 20814 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MERINGI DS disease or condition resulting in death) weeks /Medical Due to (or as a consequence of): Examiner - Imphosphe teakening Lears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached 9 Unknown is been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩0 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of ial or Attending P is after death.

al Director: After ed in by the funer. After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M1 -00066893 MM May 05, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed

MAURO SARMIENTO

2. Registrar's Signature

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 5:50 PM **Physician** 000 /Medical 4b. City, Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 1 M 2 F Hours **Funeral** MARY 25-1971 119-82-0003 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 Yes 2 No Funeral Director Baltimore Ma 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21213 S items 23a 3913 DRIVE and 2 should be filed within 72 hours after death 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 Yes 2 No ö Black Specify: ρ 3 Widowed 4 Divorced "natural". Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Athletic Club other than tock 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be is marked of Lorraine Charles Ceatino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2;
Department of Health ar
Important: If item 27 is
any injury or other trau Baltimore 3913 Shannon DRIVE 20c. Location - City or Town, State 20b. Place of Disposition (Name of pemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 13 Woodlawn, Wd 4 🗌 Do mean 5 Other (Specify) 22. Name and Address of Facility/Miller's Metropolitan Chapel 21. Sign Bacto. Broad way 1639 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat List only one cause on each line. Approximate Interval Between Onset and Death shock, / heart failure Immediate Cause (Final rewo sar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò of Vital Records, No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform funeral director, page 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Xippatient 2 ER/Outpatient 3 DOA မ 28a. Dale of Injury 28d. Describe how injury occurred 27. Mayner of Dooth 28b. Time of 28c. Injury at Work? Certification: 1 A Natural 2 ccident 5 Pending investigation 1 Yes 2 No death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide within 24 hours a

To the Funeral D Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre SLOT MARSNAIL, MD 600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Maryland 21215-0036

Baltimore,

P.O.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05/07/2009 Year 4:50 р м **Physician** Linkus George /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 2715 Daisy Ave If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days Hours Months 1 X M 2 □ F 07/02/1934 Shamokin, PA 74 216-30-6684 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐Yes 2 X No Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 2715 Daisy Ave Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes. Give 3 X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Refrigeration Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Regina Waselewski George Linkus ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2720 Daisy Ave Baltimore, MD 21227 John Linkus - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Lakeview Memorial 05/12/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Arbutus, MD 21227 23a. Part1. Enter the disease, of complications that cause in shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Meta **Physician** disease or condition resulting in death) Tail /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or Attending Physician: The within 24 hours fter death. performed? 1 ☐ Yes 2 Z No 1 ☐Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours fter deal completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 38662 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) R.J. Walsh Bathmore WILKENS 100 Registrar's Sign 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03598 2009 15221 State of Maryland / Department of Health and Mental Hygiene Crystal Leggins Certificate of Death Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 5, 2009 0146 hrs Medical Examiner Crystal A. Leggins 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7 Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Country) Hours Months Days 9-27-2003 MD Director 218-67-6793 5 1 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a, State Y Yes 2 No 23a or 28a-f show notified at once. Baltimore MD N/Ahours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21201 568 Orchard Street 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. or items. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X XNever Married 2 Married Yes Specify Black Yes 2 X No specify. Yes. Give Yee Divorced Widowed 4 à 16b. Kind of Business/Industry N/A 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) N/A College (1-4 or 5+) Flementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. 21215-0036 N/AN/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) or other traumatic event, the marked Be Donna Mason Keith Leggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 is MD 21201 Q M 568 Orchard Street Balto, Donna Mason-Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5-11-09 Randallstown, MD King Memorial Pk Donaffon 5 Other Specify: East F/H March 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee 3mg Mille 1101 E. North Avenue Balto, MD 21202 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** een Onset and failure. List only one cause on each line. Death /Medical Pneumonia complicated by pulmonary abscess Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and AMENDED 23a,27,per ME g891 5/29/09 TT Physician/Medical ysician a burial -X UNPENDED Box 68760, 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE the attending phy ed for use as the b 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. Yes 2 V No 3 Probably 4 Unknown þ Completed Records, 24b. Were autopsy findings available 24a. Was an certificate has been page 2 should prior to completion of cause of autopsy death? performed? No 1 V Yes ✓ Yes 2 No 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 this 1 ✓ Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification 1 X Natural Yes 2 Director: Pending 24 hours after death 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide o the Funeral I (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

State Registrar

2. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 2

2 2009

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

ORIGINAL

O.C.M.E.

114-Penn Street, Baltimore, MD 21201

May 5, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20h per Fh g891 5/12/09 TT State of Maryland 7 Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle **Physician** /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ken 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 85 Yrs. . Sex 1 □ M 2 ★ F **Funeral** Min 220-22-544 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It e Medical Exempter must be notified at once. 1 Xes 2 No Director Himore 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ry/Secondary (0-12) College (1-4or 5+) se's 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) heodora William Herman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) lineward Batto-MD21118 ana, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 110155 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Zheimer **Physician** QEMento 6 5 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner year maln Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7,200 0056254 Lan NI IND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Nan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hynter, DonTae Therman Lee 23153 M 05 01 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baitimore, Balti more Mercy inedical anter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Months 1**⋉**M 2□F MD Yrs. 2009 10 23 Director Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits MD1 Yes 2 No Battimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 USA OSSWOOD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: Blac Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ihurman unter Pages 1 and 2 should nent of Health and Men ၉ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5110 Crosswood permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra Hoderson-mother 1-10. <u>ratiana</u> Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Valle 109 Dulaney imonium 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lice see 2. Name and Add ess of Facility Brehms 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Grade 4 IVH Bilaterally 7 days /Medical Due to (or as a consequence of): Examiner (ex- 23 3/7 who gest age prematuny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buris Physician/Medical NIA IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 low birth weight Pulmonary 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 autopsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 3□ DOA Certification: To 1 Inpatient 2 ER/Outpatient this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only

Division or Vital Records, P.O. Box 68760, Hospital or Attending 24 hours after death Funeral Director: within 24 hor To the Fune completely fi

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Michelle Chudon, M.D.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 St. Paul Street, Bothmere, UD 21202

29c. License number

D68848

29d. Date signed (Month, Day, Year)

5/2/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per Inf G892 6/08 09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 5:02 20009 Ам Georgia Langenfelder Linthicum /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4800 Wards Chapel Rd. Owings Mills Baltimore Wings rull | If Under 24 Hrs. | 8. Date of | If Months | Days | Hours | Min. | Sept. | 1936 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In yrs. last birthday) Maryland 1 □ M 2 X F 72 213-38-7439 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Event in a must be notified at 1 ☐ Yes 2XXNo Director Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 4800 Wards Chapel Rd. United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify. <u>}</u> Specify: 3 ☐ Widowed 4 🎇 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any lipiry or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Ullrich George H. Langenfelder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 108 Baltimore, MD 21023 George E. Linthicum IV/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory May 12,2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card of or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (cr as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) P.0. 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2. No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 □Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: / by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certific person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day) Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician MILITER 26 AM 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DITIMORE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Hours 1**2** M 2□ F 220-38-7050 DECEMBER 16,1941 VIRGINIA Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County Show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment mest be notflind at 1 ☑Yes 2 ☐ No BALTIMORE Directo MARYLAND 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 3601 Funeral 14 Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No ģ BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR 2TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) (かん・じればんじょん) 17. Father's Name (First, Middle, Last) Be 2 should be fi MINTER CATHEKINE ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RD, BALTIMURE, MD 21215 ELLAMONT Health a (WIFE) 3601 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 7 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEM. PARK 05/15/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W JR. FUNERAL 21. Signature of Funeral Service Licenses eleans 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final minutes **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (gras a consequence of): burial-transi and signed by the attending physician be detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Dav 1∐Yes 2∐No 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 1 De Natural funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed use of death (Item 23a) (Type, Print) FUTAWOL, BACTIMORE ETER 2425

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month AIJBUB 10:56 A M 2009 MARHEFKA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner J30HURA HHA BALTI MORE-WASHINGTON MEDICAL CENTER CLEH BURNIE 8. Date of Birth (Month, Day, Nov. 21 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday. **Funeral** Hours Min. Year) 1 ☐ M 2 ☐ F Davs 93 262-07-6736 1915 FL Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f shov 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Glan Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7837 Baltimore Annapolis Blvd. 21060 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Spanish White Specify: \$ 3 Widowed 4 Divorced 'natural" Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental 27 is marked of traumatic ever Unknown Sarmieto Dominica Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 is or other tra Walter Marhefka (spouse) 7837 Baltimore Annapolis Blvd., Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date May 11 permit. Page Department o Important: If any Injury or 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2009 Service Ligens 22. Name and Address of Facility 21. Signature of Funeral Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Part 1. Enter the Sease, or complic to shock, or heart fail ve. List only one care ns the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the Approximate Interval Between Onset and Death se on each line. Immediate Cause (Final **Physician** PERFORATED COLON disease or condition resulting in death) G HOURS /Medical Due to (or as a consequence of): Examiner DIVERT CULLTIS ZY HOURG Sequentially list conditions, if any and the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) of Vital Records, P.O. 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown COROLLAY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death. ineral Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L Medical 29a. Certifier 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chillenna Jes Cionapeco 41F53000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO JOSÉ GIANGRECO 301 HOSPITAL DRIVE, GLENBURNIE, MD ZOIGI 31. Date filed (Month, Day, Year) State Registrar

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Division of Vital Records, P.O. Box 68760, certificate this Aftert

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Exercitor any Injury or other traumatic event, the Medical Exercitor any once.

Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

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Hospital or Attending To the Hospital or Attenc within 24 hours after death To the Funeral Director:

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filled in by the funeral director,

Completed Be Certification: To 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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, Baltimore, MD, rac's Signature

Registrar

21239 Dr. Monthida Fangtham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 | 5228

		For State Certificate of Death	Reg. N		7 1021					
Physician		Decedent's Name (First, Middle,Last)	ate of Death onth Day		Time of Death 0149 hrs					
edical Examine		Glaties bryall (Otal	ay 7, 2009	4c. County of Death	01431113					
	4	Ha. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Columbia		Howard						
		5174 Cambonit Cano	Date of Birth (M	IM/DD/YYYY) 9. Birthp	lace (State or					
Funeral Director		Months Days Hours Min.	arch 7,	Foreign	Maryland					
*	_	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits					
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Aaryland 28a-f show 1 at once.	\smile	Maryland Howard Columbia 10e. Street and Number 10f. Zip Code	10g. 0	Citizen of What Countr	y?					
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er dez		1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify:		Specify: Whit	e					
ural'	മ്⊩	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work of	done 16	b. Kind of Business/Inc	lustry					
72 hou	를 - -	Elementary/Secondary (0-12) College (1-4 or 5+)								
036 ithin ne.	ompleted	12 Landscaper		Self-Emplo	yed					
1215-0036 Id be filed within 72 hours after featal Hygiene. narked other than "natural" event, the Medical Examina	91	17. Father's Name (First, Middle, Last)		den Surname)						
121 d be fi ental arked	B	Donald Morar Susie Ra		r. City or Town. State.	Zip Code)					
D 21 should and Med 7 is mai	ᄋ									
y MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	2012	John Morar, Brother John Morar, Brother 20a. Method of Disposition John Morar, Brother Jo	ite 2	0c. Location - City or T	own, State					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical Control of the		1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory Inc. 05/08	/00	Baltimore,	Maryland					
timen rtant										
Bal Depa Depa injur	ΠŘ	Thomas Gregory Thomas	Maryıa altimor	and, inc. ce. Marvlar	d 21228					
Physician	1	23a, Part I, Enter the disease, or complications that consed the distance in the mode of dying, such as cardiac or res	spiratory arrest,	, shock, or heart	Approximate Interval Between Onset and					
Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a Hanging			Death					
taminer		or condition resulting in death) Due to (or as a consequence of):								
	إي	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):								
	<u>اة</u> ِ	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
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876 ifficate		23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy	1	Month D	ay Year					
Box 68760, e death certificate be the attending physic ad for use as the bur	Physician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		Į.						
Bo ne dea	hys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?					
P.O. Best that the designed by the seedetached for		Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in a circle.		2 No 3 Prob						
S, F quires an sign	Completed by		24a. Was an		opsy findings available					
ords, aw requinas been a			autopsy perform	ed? death?	ompletion of cause of					
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n of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should	Be [25. Was case referred to medical examiner? 4. Hospital: 1. Inpatient 2. FR/Outpatient 3. DOA Other; 4. Nursing H.		esidence 6 🗸 Other	Scene					
f Vit Physic at dir	인	1 V Yes 2 No 280 Date of Injury 280 Injury at Work? 281	d. Describe ho	w injury occurred						
n of ding Pl 1. After		1 Natural 5 Pending FOUND: 1 Yes 2 ✓ No Su	ıbject hang	ed self						
Sior Attend r death. ector: by the	cati	2 Accident Investigation May 7, 2009 0130 hrs			ral Route Number, City					
Division spital or Attendin hours after death. meral Director: A	Certification:	Suicide Could not be determined (Specify) Single Family	or Town, Sta 74 Lambskin	ate) Lane, Columbia, M	D					
Hospital 24 hours Funeral	ပ	29a. Certifier A Continue Physicians. To the best of my knowledge, death occurred at the time, date and place, and dur	e to the cause	(s) and manner as state	ed.					
To the Host within 24 hc To the Fun	اج	(Check only 1 Certifying Physician: To the best of the water death occurred at the thirty date and place and place at the thirty date at the thirty	ne time, date ar	nd place, and due to th	e cause(s)					
,	dical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo.						
	Medical	and manner stated.								
	Medical	29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and a dress if person who completed cause of death (Item 23a)		29d. Date signed (Mo.						
		29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8, 2009 **Physician** 9:32 P M Marie G. Mundie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 117 North Bend Terrace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 7, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1925 Months Days Min. 1 □ M 2X F 216-18-4969 83 Dec Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner is use be notified at 1 ☐ Yes 2 No Glen Burnie Marvland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or : 21060 **USA** 117 North Bend Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No White Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Glinka UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michele Priebe, Daughter 117 North Bend Terrace Glen Burnie, Maryland 21060 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or oth orice. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/11/09 Baltimore, Maryland 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ENZ Stengy 4 rsms a /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performe 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records. within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur

> State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certific

1tigh way 31. Date filed (Month, Day, Year) Registrar's Signature

Crain

and manner stated

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mayer and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

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29d. Date signed (Month, Day, Year)

05,09,2000

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** May 2009 Calvin Leroy Mills р м 5:43 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3334 Strickland Street Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 🕅 M 2 🗆 F 80 219-22-1067 1928 13, Aug MD Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1XYes 2 ☐ No Director MDBaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3334 Strickland Street 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: \$ Caucasian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Production s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. William Nicolas Mills Bertha Priebe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Mills - Wife 3334 Strickland Street, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 5/11/2009 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore City, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 21. Signature of Funeral Servi 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NONSMO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Justo (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page certificate 1 ☐Yes 2 ☐ No 1 🗌 Yes 2 No To the Hospital or Attending Physician: After this certification funeral director, r 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: . completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 15231

		1- For State Certificate of Death	Reg. No			
Physicia	n/	1. Decedent's Name (First, Middle,Last)	Date of Death Month Day Year 1357 bro			
ledical Examir	er	Thomas Morgan Ma	ay 3, 2009	1237 1115		
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	14	lc. County of Death		
		Johns Hopkins Hospital Baltimore	Data of Diath (1.0)	M/DD/YYYY) 9. Birthplace (State or		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. 1 Months Days Hours Min.		Foreign		
Director		220-24-6029 1X M 2 F 80 Yrs. Months 53,5 100 100	11-11-	-1928 Country) VA		
	-	Usual Residence of Decedent		10d. Inside City Limits		
/ any		10a. State 10b. County 10c. City, Town or Location				
ınd show	5	MD N/A Baltimore		1 X Yes 2 No		
Maryland 28a-f show 1 at once.	Director	10e. Street and Number A p.† 10f. Zip Code	10g. C	itizen of What Country?		
the Na or 3	吉	201 N. Washington Street 1103		USA		
with us 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Luban, Mexican, Puerto Rica		14. Race - American Indian, Black, White, etc.		
death r iter	Ĕ	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rical Yes 2 X No	11, 010.)			
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5-0036 led within 72 hours after the within matural". other than "natural".			done 16b	. Kind of Business/Industry		
6 1,72 h	ompleted	Elementary/Secondary (0:12) k College (1-4 or 5+) unk Laborer Steel	В	ethlehemSteel		
5-0036 led within 7 Hygiene. other than	Ĕ.	17 Father's Name (First Middle, Last) 18.Mother's Name (First	at Middle Maids	on Surnama)		
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2121 ould be fi Mental marked ic event,	Be	Branch Morgan Marie B 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	rown Route Number	City or Town, State, Zip Code)		
MD 21215-0036 4 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	은	Grandson		ï		
, Mand 2 and 2 ealth em 2 iraun	- 1	Courtney L. Jordan 341 / Parklawn Aven 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Da	ate 200	c. Location - City or Town, State		
Ore ges 1 a of Hi If it	- 1	1 X Burial 2 Cremation 3 Removal from State Oaklawn Cemetery 5-12-	2000	Balto, MD		
Lim Pag ment tant:		4 Donation 5 Other Specify:				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical				ast F/H		
	_	23a. Part I. Egter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or res	enue B	alto, MD 21202 shock, or heart Approximate Interval		
Physician Medical		failure/List only one cause on each line.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Between Onset and Death		
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Diseasea Due to (or as a consequence of):				
		h				
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	miner	cause. Enter Underlying Cause (Disease or injury that initiated c.				
sd sit	Exa	events resulting in death) Last Due to (or as a consequence of):				
760, ficate be executed g physician and the burial - transit	ä	d.				
D, be en	edical	UNPENDED AMENDED		SO L Patro C Jaliana		
760, ficate be g physicist the buri	≥	18 F FEMALE 230: If yes, ductoffie of pregnancy	i i	23d. Date of delivery Month Day Year		
Box 68: death certificate attending	sician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)				
Bo) e death the att	ıysi	1 Yes 2 No 9 Unknown g Unknown				
O. I at the d by t	/ Phy			co use contribute to the cause of death?		
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	d by	chronic alcoholism	1 Yes 2	Probably 4 Unknown		
ords, w requires to been a should	ete		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
e law e has ge 2 sl	Completed		performed 1 ✓ Yes 2	death?		
tal Rec cian: The l certificate				10 10 2 10		
on of Vital Records, tending Physician: The law requirement. The law requirement. After this certificate has been some function, page 2 should the funceral director, page 2 should the funceral director.	Be	examiner? [Hospital: Innation 2 FR/Outnation 3 DOA Other Nursing H		sidence 6 Other:		
Physic Physic er this	٦.	27. Manner of Death 28a, Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c.	d. Describe how	injury occurred		
nding Ph nding Ph th. :: After t	io	1 V Natural 5 Pending (Month, Day,Year)				
Sio	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f	f. Location (Stree	et and Number or Rural Route Number, City		
Division tal or Attendi rs after death.	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State	e)		
lospit 1 hour 1 hour 1 hour		I ZYA CETITIET	e to the cause(s)	and manner as stated.		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: ∧	lica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the	e time, date and	place, and due to the cause(s)		
To with	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		d. Date signed (Month, Day, Year)		
	_	O.C.M.E.	E N	May 4, 2009		
		36. Name and address of person who completed cause of death (flem 23a)				
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201			
9	ate	24 Data filed (Manth Day Voor) 32 Penistrar's Signature.				
Regis						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:36 6W MROWCZYNSK: MAY 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SIUAUB UBJO JOHUSA UHA BALTIHORE-WASHINGTON MEDICAL CENTER 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F 6,1971 MD 212-88-5043 37 Dec. Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Funeral Director Anne Arundel Severn MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21144 U.S.A. 797 A Jennie Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2X No White Specify. Specify: ş 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William D. Embleton Ramona Kuczinski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 s Iment of Health ar lant: If item 27 is permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once. Mr. Phillip Mrowczynski/Husband 797 A Jennie Drive Severn, MD 21144 Date 14, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tin Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Glen Burnie, MD Glen Haven Mem. Park 4 □ Donation 5 □ Other (Specify) 21. Signature Guneral Service Lipensee 22. Name and Address of Facility Singleton Funeral & Cremation Servcies PA 1 2nd Ave. SW Glen BUrnie, MD 21061 6122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEBSIS 3 DA45 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner J MONTHS A IMOHUBUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 BNo Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown HODEKIN, 2 CAMBHOMA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒No 24a. Was an 2 **X** No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DDA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, 24 hours after death Funeral Director: Hospital within 2. the

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

La consulta per Cioneros Ho

CUILLERMO JOSE GIANCRECO

MAY 122009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Ka Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 0005711A

301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner **Funeral** Director

Be Completed by Funeral Director

ဥ

_ For		State of M	1arylan	d / Depa	rtment of Hea	Ith and N	/lental Hy	gien	eann	0.	1522
1 - State Registrar				Cei	tificate of Dea	ath		Reg. N	. 200	7	1969.
1. Decedent's Nam	e (First, Middle,	Last)					2. Date of De	_			Time of Death
Do	orothy	Louise Ma	rsden				May 9,	20	09 Year		4:15 A ^M
		give street and numbe	r)		4b. City, Town, or Loca			4	c. County of Dea		
9616	Labrado	or Lane			-	sville			Baltin		
5. Social Security N		6. Sex 7. A 1 ☐ M 2 🖾 F	ge (In yrs.	last birthday)		Inder 24 Hrs. ours Min.	8. Date of Bir (Month, Da Feb. 2	th i <i>y, Ye</i> a.	9. Bir	rthplace ountry)	(State or Foreign
578-24-00		TLIM ZIM F	86	Yrs.			Feb. 2	7,	1923Wash	ing	ton D.C.
Usual Residence o	f Decedent 10b. County		100 Cit	y, Town or Lo	nation					10d li	nside City Limits
											☐Yes 2 No
MD	Balti	Lmore		Cockey							
10e. Street and Nu	mber				10f. Zip Code			10g. C	citizen of What C	ountry?	
9616 La	abrador	Lane			21030				USA		
11. Marital Status		12. Was Deceder Armed Forces	t Ever in U. ?	S. 13.\	Vas Decedent of Hispar f Yes, specify Cuban, Me	nic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Whit		dian,
1 Never Marr	ied 2□ Marrie 4 ဳ Divorced		No			ecify:			Specify:	Whi	.te
(Sno	15. Decedent's	s Education t grade completed)			dent's Usual Occupation kind of work done during		ring	16b.	Kind of Business	/Industr	y
Elementary/Seco		College (1-4o	r 5+)		OO NOT use retired)	, most of work	nig				
12	2	N/A		Ent	repreneur				rafts		
17. Father's Name	(First, Middle, L	ast)			18.	Mother's Name	e (First, Middle	. Maide	en Surname)		
Hanry N	1. Fow]	Ler				Gert	rude La	ngf	ord		
19a. Informant's N					g Address (Street and I			, ,		,	le)
		ld/Daughter			Labrador L						
	•	3 □ Removal from Stat	e Sla	Place of Dispo emetery, cren te Kid	sition (Name of natory or other place) ge Cemetery	May 200			Location - City or Delta, F		State
21. Signature of Fi	uneral Service L	Mighael J.	Flag		Name and Address of emmon Funer O W. Padoni	Facility al Home	e of Du	lan.		у, :	Inc.
23a. Part 1. Enter	la sease, or o				er the mode of dying, su				, 110 210	App	roximate
shock, or hea	art failure. List c	nly one cause on each	line.	0.70	Walter II	S2 25 1 2	2			Inte Ons	rval Between set and Death
disease or condition resulting in death)	on	-a. 15C			FOICMYO.	PATHY	<i>(</i>				MONTHS
,		Due to (or a	is a consequ	uence of):							
Sequentially list co	nditions,	b	u o stanta	Output de COMPAT D							
cause (Disease or	erlying -	Due to (or e	8 B. DUNBERO	Merson 12035						Ì	
that initiated events resulting in death)	5	c									
resulting in death)	Last	Due to (or a	is a consequ	uence of):							
	'	d								-	
IF FEMALE:											
23b. Was deceden		23c. If yes, outcom			Ectopic pregnancy				23d. Date of de		
in the past 12 1 □ Yes 2 l		4 Pregnant	at time of o		Other (specify)				Month	Day	Year
9 Unknown		9 - Olikilowi						-			
Part II. Other signi	ficant condition	ns contributing to death	but not resi	ulting in the ur	nderlying cause given in	Part I.	23e. Did	obacco	use contribute t	to the ca	use of death?
							1 🗆	Yes	2 □ No 3 □ F	robably	4 Unknown
							24a. Was	an	24b. Were a	utopsv f	indings available
							auto		prior to death?	comple	tion of cause of
OF Mary							1 ☐ Yes	2 2		s 2 🗆	No
25. Was case refer	red to medical				26.	Place of Deat	th (Check only	one)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exer eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial within 24 hours after death.

To the Funeral Director: A

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylanc Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examination.

Physician /Medical Examiner

									autopsy performed? 1 🗆 Yes 2 🛣 No	24b. Were autopsy lindings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case refer	rred to medical						26. Place of Dea	eth (C	Check only one)	
examiner? 1 ☐ Yes 2 🔀	1No	Но	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □Yes 2 □No	280	d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6	е	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree by)	t, facto	ory, of	fice	28f	Location (Street and City or Town, State)	l Number or Rural Route Number,
29a. Certifier (Check only one)			cian: To the best of my kno er: On the basis of examina and manner stated.							and manner as stated. place, and due to the cause(s)

29b. Signature and the

29c. License number 06 4 3 9 5

29d. Date signed (Month, Day, Year) MAY 10, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN 6565 N CHARLES ST, SUITE 209 BALTIMORE, MD 21204

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARSHALL ean homasine /Medical 4c. County of Death ... 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice GILCHRIST DINSSIM, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) MARYLand 5. Social Security Number 212-56-8 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) **Funeral** Months 1 □ M 2 🗗 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is "satical Experience outsites notified at any injury or other traumatic event, Its "satical Experience outsites notified at 1 Yes 2 □ No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Seidel Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Specify: BLack Baltimore, Maryland 21215-0036 1 □Yes 2 No **会** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ouse Kee 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosie MARShal BROOKS Dean ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 515+eR Balto. Wd. Lenice 4302 Seidel Ave. 20c. Location - City or Town, State 20a. Methed of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (3 pecily) Date Balto. 12 109 5 22. Name and Address of Icility Willows Mouse police BROadway N. 23a. Part 1. Enter the disease shock, or heart failure. Imm. flate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. MULTASTATIC UNKNOWN Physician Driman mortas Cancel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and burial-trar The law requires that the death certificate be execu Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Completed peen s page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPUS 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attending 1 Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 1: 10 PM 2009 Newton Mary Adelaide /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1□ M 2□ Months Days Yrs Director 85 217-12-0970 13 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Columbia 1 ☐ Yes XXNo Director MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21045 8610 Snowden River Parkway #408 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ≥ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baby Formula Nutrionist University Hospital 12th_grade Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernell Hebb Vernell ဂ Obadiah Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gwendolyn Thompson-Daughter 8610 Snowden River Parkway #408, Columbia 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/12/09 Woodlawn, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 1. Sign of Funeral Service Licenses 21215 23a. Par / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final is ase or condition resulting in death) **Physician** O months OL MOUN /Medical Due to (or as a consequence of): **Examiner** exast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 NO Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐Yes 2 ☐ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2∐No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne f Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 tural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009

State

show

with

death

Pages 1 and 2 should be filed within 72 hours after

law requires that the death certificate be executed

physician

led by the attending detached for use as

signed by

this certificate has been

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

the

Division of Vital Records, P.O. Box 68760,

MARY

Hygiene.

Maryland 21215-0036

Baltimore,

d other than "natural", or items 23a or 28a-f shovevent, the Medical Evaniner runt ocnotified at

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

7019

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 7:40 P. M. 200 may Malinda Newton 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Medical Center Date of Birth (Month, Day, Year)
9-30-1924 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. 1 ☐ M 2 🔀 F Months Hours 84 VA 213-30-7225 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ¥Xes 2□No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3015 Mondawmin Avenue 21216 U S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Black Specify: 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Mallory Sallie Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Newton-Son 768 225th Street Pasadena, 21122 MD20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) YSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial |5-13-2009 | Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H warma Cu 1101 E. North Avenue Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. acrider. Immediate Cause (Final

Physician) /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it w. M. cital Expriring 1 and be ruffled at once.

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

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	disease or condition	a. Ordenousan			
	resulting in death)	Due to (or as a consequence of):			
	Sequentially list conditions, f any, leading to immediate cause. Linter Underlying Cause (Disease or injury	b Due to (or as a consequence of):		- 4	
K 1	Lause (Disease of Injury hat initiated events resulting in death) Last	c			111
	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
2	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? S 2X No 3 Probably 4 Unknown
- Parallel				24a. Was an autopsy perform 1 □ Yes 2	prior to completion of cause of
1	25. Was case referred to medical		26. Place of Deat	h (Check only one)
	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Ho	ome 5 Resider	nce 6 ☐ Other (Specify)
2	27. Manner of Death ↑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury N	28c. Injury at Work?	28d. Describe how	
	3 ☐ Suicide 6 ☐ Could not be determined		actory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
- Calcal	29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investion and manner stated.	urred at the time, date and place, gation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)
	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, Day, Year)

State

person who completed cause of death (Item 23a) (Type, Print)

MAY 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2:00 P M 2009 Nardone May 6. Shirley Ε. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Timonium 11807 Sherbourne Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 □ M 2 🕅 F Yrs Nov 8, 1924 Maryland 84 218-18-1696 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 2 🔯 No Maryland Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11807 Sherbourne Drive 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify: White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schoenberger Μ. Young Nanetta Hillard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11652 Greenpoint Road, Timonium, Maryland Leonard C. Nardone/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5/12709 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 4 Donation 5 NOther (Specify) Entombment Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
Lemmon Funeral Home of Dulaney Waryland 21093 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Approximate Interval Between Onset and Death 23a. Part 1. Fi ter the disease, or complications that caushock, or hear failure. List only one cluse on eag e inal Immedia e Cause disease consi resulting in death) month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieuse of jury) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Ye ar Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantines must be notified at

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-trans Physician/Medical

ed by the a detached f certificate has funeral director, spital or Attendi nours after death. neral Director: A

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Completed I

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Certification: To

requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 □Yes 2 💢 No
41

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

1 □Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death 1 Natural
2 Accident

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only

3 Suicide

4 Homicide

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D35170 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 CONKYNG ST BALTIMORE MARYLAND 21234 808-810 31. Date filed (Month, Day, Year)

State Registrar



within 24 hours a

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07 **Physician** Thelma Dolores Nicholson 2009 May 5:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Health and Rehabilitation Glen Burnie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/05/1929 **Funeral** Hours Months Days 1 □ M 2 □¥ 212-32-9421 80 Baltimore, MD Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.
marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. Count r than "natural", or items 23a or 28a-f sho 1 Yes 2 No Director Linthicum MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21090 10 Eleanor Avenue United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ∰Muo If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Book Binder Manufacturing Department of Health and Mental Hy, important: If item 27 is marked any injury or any injury or any injury or any 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Nicholson, Sr. Thelma Schroeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Donald Nicholson, Sr. (Brother) 10 Eleanor Avenue, Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 05/11/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licental 22. Name and Address of Facility 4107 Wilkens Avenue, Baltimore MD Hubbard Funeral Home, Inc. 21229 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and stransit the burlal-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending phate as the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ∐Yes 2 1 No Ö the detached 9 Unknown 9 ☐ Unknown signed by t ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 3 Probably 4 Unknown 1 ☐ Yes 2 📉 No Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed After this certificate I 1 ☐Yes 2 No 1 ☐ Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Itle of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

		Please Type or Print in Bla State of Maryland /				_	_	.
	-	For State Of Maryland / State Registrar		rtificate of l			Reg. No.2	9 15239
		Decedent's Name (First, Middle, Last)				2. Date of Dea	Lagar C	3. Time of Death
Physicia /Medic		Franklin Basil Owens				May 9	2009	4:45 p M
Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of D	
		Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	Westmi	nster If Under 24 Hrs.	8. Date of Birt	Carrol	Birthplace (State or Foreign
Funeral Director		219-10-8812 18 M 2□F 83	Yrs.	Months Days	Hours Min.	(Month, Da 11-25-	y, Year)	country) aryland
pu »		Usual Residence of Decedent						10d. Inside City Limits
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the N	Director	MD Carroll Wes	tmin	ster 10f. Zip Code			10g. Citizen of What	
h with	a Di	902 Rolling Ridge Rd.		21157			USA	
ems a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No Rican, etc.)		American Indian, /hite, etc.
s after	by Ft	1 ☐ Never Married 2 ☐ Married 1√☐ Yes 2 ☐ No If Yes, Give Year or Dates:	- 1	1 □Yes 2 No	Specify:		Specify: [v	
''ratural'', or items 23a or 28a-f show		15. Decedent's Education	6a. Deced	dent's Usual Occup	ation		16b. Kind of Busine	ess/Industry
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be fill hall Hed out	Be	17. Father's Name (First, Middle, Last) Frank OWens					Maiden Surname)	
should brd Me mark imatic	၉		I9b. Mailir	na Address (Street		River	er, City or Town, Sta	te, Zip Code)
nd 2 salth ar 27 is 27 is r trau								,MD 21157
of Head		20a. Method of Disposition 20b. Place	e of Dispo	sition (Name of natory or other plac	e)	Date	20c. Location - City	or Town, State
Page ment ant: I		1 🗆 Buriai 2 🗀 Cremation 3 🗀 Hemovai from State	Oakl	awn Cem	5-14		Baltimo	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Licensee					Funera .nster,M	l Home, P.A. D 21157
		23a. Part 1. Enter the disease, or complications that caused the death. E shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
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/Medical Examiner		resulting in death) Due to (or as a consequence Lung Cance)	ce of):					2 yrs
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w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date of	f delivery
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ian: T	BeC	25. Was case referred to medical			26. Place of Dea	1 □ Yes th (Check only o		Yes 2 No
hysic his ce I direc		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 ☐ Resid	dence 6 □ Other (Specify)
ling P	ion:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	b. Time of Injury	Worl		28d. Describe I	now injury occurred	
death ctor: y the i	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home.	. farm. str		Yes 2 □No	28f. Location (Street and Number of	or Rural Route Number,
tal or / s after al Dire ed in b	Certification: To	4 Homicide determined building, etc. (Specify)		•		City or Tov		
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled to the best o						
To th within To th	Me	29b. Signature and title of certifier		29c. Licens	e number 9296		29d. Date signed (A	nonth, Day, Year)
211	-	30. Name and address of person who completed cause of death (Item 23	Ba) (Type,		10-10			•
J' \ √		R. Ricketts MD 910 Washingto	n R	d. Westr	ninster	MD 21	157	
Stat Registra		R. Ricketts MD 910 Washingto 31. Date filed (Month, Day, Year) A Registrar's Signature A 12 2009	pa	Ver				
HMH 17 Rev 1/20	-	MAIL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ooreena O'Brien	State of Maryland / Department of Certificate of Ce			2009 1524				
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 2, Date of Death	3. Time of Death				
/Priysician Medical Examiner	Doreena O'Brien		Month Day May 8, 2009	Year 2035 hrs				
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. Co	unty of Death				
	314 Georgia Avenue	Glen Burnie		e Arundel				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/	YYYY) 9. Birthplace (State or Foreign Country)				
Director	218-94-4084 1 M 2 XF 43 Y	rs. Months Days Hours Min.	Apr. 1, 196					
	Usual Residence of Decedent		, 20,020					
any	10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits				
ind show	Maryland Anne Arundel Glen Burn	nie		1 Yes 2 X No				
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?				
the N tiffed	314 Georgia Ave. NE	21060	Unite	d States				
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death r iter unst	1 Never Married 2 X Married Armed Forces? If 1 Yes 2 X No	res, specify Cuban, Mexican, Fuerto i	Alcan, etc.)	William Co.				
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nours xanu	during	ent's Usual Occupation (Give kind of w most of working life. DO NOT use retir		of Business/Industry				
6 1,72 H ical E	Elementary/Secondary (0-12) College (1-4 or 5+)	·						
5-0036 led within 72 hour Hygiene. I other than "natu the Medical Exan Completed	1 Data	Systems Analyst	Heal (First, Middle, Maiden Sur					
15-1 filled if the	17. Father's Name (First, Middle, Last)							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Gordan Henry Wharran 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Alma (ing Address (Street and Number or R) 'Neil tural Route Number. City o	or Town, State, Zip Code)				
MD 2 rid 2 shou ulth and M m 27 is n aumatic								
and 2 sealth tem 2 traur	20a, Method of Disposition 20b. Place of Dispo		Date 20c. Loc	ation - City or Town, State				
Ore	1 X Burial 2 Cremation 3 Removal from State crematory or o	other place) May	14,					
ti Pag trant	4 Donation 5 Other Specify Glen Hav	en Mem. Park		Burnie, Maryland				
Baltimore, permit. Pages lan Department of Hea Important: If iten injury or other tra	21. Styn turetof Tuneral Arvice Licky ee 22.	Name and Address of Facility Lrkley-Ruddick Fur	neral Home,	P.A. ie, MD 21061				
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	r the mode of dying, such as cardiac or	respiratory arrest, shock,	or heart Approximate Interval				
/Medical	failure. List only one cause on each line.			Between Onset and Death				
aminer	Immediate Cause (Final disease or condition resulting in death) a. Cardiomeraly with b Due to (or as a consequence of):	iventricular dila	tation					
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50, te be nysicia buria			23d. E	Date of delivery				
cords, P.O. Box 6876. The requires that the death certificate that been signed by the attending phy 2 should be detached for use as the budleted by Physician/M.	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna		onth Day Year				
th cer trendi	1 Yes 2 No 9 V Unknown	Other (Specify)						
Bo lee dea the a the a leed fo	1 Yes 2 No 9 V Unknown 9 Unknown	Death	220 Did tobacco use	e contribute to the cause of death?				
P.O. s that the greed by detach		e underlying cause given in Part I.						
S, F	<u> Hepatic steatosis</u>							
» requal shoul			24a. Was an autopsy autopsy findings available prior to completion of cause of					
Records, The law requires ficate has been signage 2 should be Completed			performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 No				
二	25. Was case referred to medical	26.Place of Death (Check	only one)					
Vita Nysicia this ce Il direc	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other Nursin	g Home 5 Residence	e 6 Other: Scene				
n of hing Ph After t funeral	27. Manner of Death 28a. Date of Injury 28b. Time of Month, Day Year)	of Injury 28c. Injury at Work?	28d. Describe how injury	occurred				
on auth. or: A	1 X Natural 5 Pending	1 Yes 2 No						
Division o spiral or Attending fours after death. neral Director: After filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	treet, factory, office building, etc.	28f. Location (Street and or Town, State)	Number or Rural Route Number, City				
Dividal outra al paral Dividad illed	4 Homicide determined (Specify)		or rown, otato)					
Hosping Sely True	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, and	due to the cause(s) and r	manner as stated.				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus and manner stated.							
F 3 F 3 E	29b. Signature and title of certifier	29c, License number		ite signed (Month, Day, Year)				
	(c. hunn	O.C.M.E.	May 9	9, 2009				
$\langle \langle \langle \langle \rangle \rangle \rangle$	30. Name and address of person who completed cause of death (Item 23a)							
(M)	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Po	enn Street, Baltimore, MD 21	201					
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7						
Registra	MAY 1 2 2009 Resure B. A.	arkel		OCME				
DHMH 17 Rev 1/2001	ORIGIN	NAL		Comme				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2:10 2009 Eugene G. Peters 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 1 Year Birthplace (State or Foreign Country) Months Hours Days 1**X**M 2□ F NOV 27, Pennsylvania 191-20-5591 1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No **Baltimore** Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21228 715 Maiden Choice Lane, CC422 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) **5+** Elementary/Secondary (0-12) Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Meszaris Julius Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 715 Maiden Choice Lane, CC422 Catonsville, MD 21228 Frances M. Peters/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. May 12, 2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG Due to (or as a consequence of): e of delivery Day Year ibute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at

nd 2 should be filed within alth and Mental Hygiene. 27 is marked other than 'r traumatic event, the Mental County in the Mental County

item 27

permit. Pages 1
Department of H
Important: if iter
any injury or oth

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director MD

Funeral

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Completed

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-transit as

Division of Vital Records, P.O. Box 68760

completely filled in by the funeral Medical Certif

Exam	that initiated resulting in d
nysician/Medical	IF FEMALE: 23b. Was de in the pi 1 □ Yes 9 □ Unl
by Pr	Part II. Other
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To Be	25. Was case examiner 1 ☐ Yes
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29a. Certifier

(Check only one)

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ary, leading to immediate ause. Enter Underlying ause (Disease or injury and initiated events	Due to (or as a consequence of):		
nat initiated events esulting in death) Last	c Due to (or as a consequence of):		
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FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date Mor
art II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contr
		24a. Was an autopsy performed 1 \(\begin{array}{cccccc} 1 \text{ Yes} & 2 \(\begin{array}{ccccc} 2 & \text{ Images} & 2 \(\text{ Images} & 2 \(Images	
5. Was case referred to medical examiner?	26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 Inperior 2 FR/Outperior 2 DOA Other:	town 5 17 Decidence	0 00

of Death 5 Pending ral

investigation dent 6 ☐ Could not be determined 4 Homicide

28a. Date of Injury (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CURTIS

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

DOU91865

HUSPITAL

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) MAY 11,2009

BALTIMORE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

20

MARLES 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

AGNES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Joseph Ritchie Hospice 8. Date of Birth 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year)944 Min. Months Days Hours 1 M 2 F Maryland Mar. 219-40-0650 65 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Medical Example 2000. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Elkridge MD Howard 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21075 United States 6305 Rowenberry Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian 1 Never Married 2 Married White 1 □Yes 2 No If Yes, Give Year or Dates: Specify Completed by 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounts Receivable Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Williams Dorothy ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8977 Sky Rock Court, Columbia, MD 21044 19a. Informant's Name/Relationship (Type. Print) Lisa Williams - Daughter 20b. Place of Disposition (Name of Menadow Tide & other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5 Other (Specify) 5-12-2009 4 Conation Memorial Park Elkridge, MD uneral Sa Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Fart 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Correr **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): requires that the death certificate be Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 1 ☐ Yes 2 No 5 Other (specify) Ö 9 Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś þ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) +0501Ce. 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ping

32. Registrar's Signature

4006426

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O5 Year **Physician** ACF RICIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospice of Chesapeake Anne Arundel Harwood Hours Min. 8. Date of Birth (Month, Day Sept. 30 9. Birthplace (State or Foreign If Under 1 Year_ Social Security Number 7. Age (In yrs. last birthday) ^{Year)}1927 Funeral Months Days 1□ M 2 F California Sept. Yrs. Director 565-34-1253 81 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examirus the notified at once. 1 □Yes Ž□No Director Falls Church VA Fairfax 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3418 Surrey Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \text{No} \) Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes, Give Year or Dates: Specify 2 white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 4 Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Wade Charles Clark Lee ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Overhill Place, Edgewater, MD 21037 Jeffrey Place (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park May 8, 2009 Falls Church, VA 22. Name and Address of Facility National Funeral Home Drandon 7482 Lee Hwy, Falls Church, VA 22042 CC0458 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 HNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Other (Specify) HO Hospital: Other: 4 Nursing Home 5 Residence HUSPIE 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred HUSE 28c. Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) DEFENSE HAR 31. Date filed (M . Registrar's Sig State

Registrar

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		For State Registrar	State of Ma	•	partment of F ertificate of		iu ivientai n	ygrene Reg. No. 🧳	000	1 1 5	: 01.
		1. Decedent's Name (First, Middle, Las	st)	-			2. Date of D Month	eath Day	Year	3. Time of	Death
Physicia /Medic	_	Victor	J	Palacor	olla		May 7,	2009	16ai	4:45	a ^M
Examine		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o		Death		nty of Death		
		1031 6th St.			Glen Bu				e Arun		
Funeral Director		217-52-8857	ex 7. Age	6 (In yrs. last birthda 57 Yrs	Months Davs	If Under 24 Hours	Min (Month, L	Day, Year) 26, 195	1 Mary	place (State on ntry) 1and	o <i>r Foreig</i> n
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside C	ity Limits
Mary -f sh	Į.	Maryland Anne Ar	unde1	Glen Bu	ırnie					1 ☐ Yes	2 ▼ No
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?	
h with		1031 6th St.			210	60		USA			
deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 1	Was Decedent of H If Yes, specify Cub	Hispanic Origin	? (Specify Yes or N	lo- 14. F	Race - Americ		
filled within 72 hours after death with the Maryland filled within 72 hours after death with than "natural", or items 23a or 28a-f show with the Medical Examiner must be notified at out, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married	1 ∐ Yes 2 🛣 N If Yes, Give	lo	1 □Yes 2 X No	Specify:	, ,		ecify.Whit		
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withi jiene. r thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Employed	•		Pool Ta	able M	echani	LC
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uld be Menta arked	2	Joseph C.	Palacorol	.1a		Mary	L.	Gepp	i		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann permit. Pages 1 and 2 should be filed within 72 hours after death and Mantal Highene. Inpoprame: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, Inc Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (**	I	ailing Address (Street			-		o Code)	
and and lealth m 27 her tr		Terry L. Palacoro	lla (Wife)		31 6th St.	·	<u>`</u>	,			
ges 1 t of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Discemetery, of	sposition (Name of crematory or other place	ce)	Date	20c. Location	on - City or To	own, State	
t. Partmen tant: njury		4 ☐ Donation 5 ☐ Other (Specify		tGlen Hay							and_
permi Depa Impo any it		21. Signature of Funeral Service Licen	isee		22. Name and Addre						
		23a. Parl 1. Enter the disease, or com	nlications that caused	the death. Do not	3620 Wilke				D 2122	.9 Approxima	ite
		shock, or heart failure. List only	one cause on each lin	ie.	enter the mode of dyr	-	1 Cer	urroot,	12	Interval Be	tween
Physician /Medical		disease or condition resulting in death)	a. Due to (or see	a consequence of):	Plan	COVO	· Ce L			6 Me	nu
Examiner			Due to (or as a	a consequence or).							
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ertific	Mec	IF FEMALE:	23c. If ves. outcome								
eath certific attending p	sician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 Ectopic pregnand	су		23d.	Date of deliv Month	,	Year
the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	tille of death	5 ☐ Other (specify) _						
	y Phy	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	e underlying cause giv	ven in Part I.	23e. Dio	tobacco use o	contribute to t	the cause of	death?
quires n sigr	d by						1 🗆	Yes 2 N	o 3∏ Pro	bably 4 📉	Unknown
w rec	Completed						24a. Wa	as an 24	4b. Were auto	opsy findings	available
he law te has age 2 s	mo						per	topsy formed?	death?	ompletion of	cause of
an: rtiffica tor, pi	a	25. Was case referred to medical		·		26. Place of	1 ☐ Yes Death (Check only		1 □Yes	2 No	
nysici	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	tient 3 DOA Oth	ner: 4 🗆 Nursi	ing Home 5 1 Re	sidence 6 🗆	Other (Speci	ify)	
ng Pl		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inju	ry 28b. Tim		iry at rk?	28d. Describ	e how injury oc	curred		
eath. or: A the fu	gatic]Yes 2□No					
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, c. <i>(Specify)</i>	street, factory, office			(Street and Nu own, State)	ımber or Rur	al Route Nur	nber,
pital ours a eral C		29a. Certifier Certifying Ph	nysician: To the best of	of my knowledge d	eath occurred at the t	ime date and	place, and due to the	he cause(s) and	d manner as	etated	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		niner: On the basis of and manner sta	examination and/o							s)
To the		29b. Signature and title of certifier			29c. Licens			29d. Date si		Day, Year)	
		1 mark	ayor	1-1)	D	3950	5	May	7, 2	1009	
61		30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	pe, Print)	1 2	^ D ^	4	100	IND.	
1 A		Yndhish Ma	arkan	305	Hospital	by,	gun 15	um	ex, I	210	161

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	e of Mary	yland /	•	artment of F <i>rtificate of</i>			ental Hy	giene Reg. No.	71111	9	15245
			Registrar 1. Decedent's Nam	e (First, Middle,	Last)			001	inicate of	Dodin		2. Date of De	eath			3. Time of Death
	Physicia		Wa	lter M	elvin	Pres	ton,	Jr.				Month 100 Ay	Day	200	-	23:15 PM
	/Medic Examin		4a. Facility Name (-				4b. City, Town, o				4c.	County of D	eath	
	SINAI HOSPITAL OF BALTIMORE BALTIMORE															
	Funeral		5. Social Security N 215-30-		6. Sex X∷X M 2□	-	in yrs. last l I G	birthday) Yrs.	If Under 1 Year Months Days	Hours	24 Hrs. Min.	8. Date of Bi	ay, Year)		Countr	
	Director		Usual Residence o			/	6					June 5	, 19	32	6 10	rida
	yland how		10a. State	10b. County		10	Oc. City, To	own or Lo	cation						100	d. Inside City Limits
	e Mai	Director	MD	Carro	11		Syl	kesv	ville							1 □Yes X X No
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	eath v	Funeral	-	3rd	Ave.	Apt Decedent Eve				1784 Hispanic Or	rigin? (Spe	cifv Yes or N	0-	U.S 14. Race - A		n Indian.
٥	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the m 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Practical Examiner must be notified at or other traumatic event, the Practical Examiner must be notified at			ied 2 Marrie	Arme	ed Forces? /es X (X)No s. Give		1	Was Decedent of H f Yes, specify Cub 1 □Yes ※X No	an, Mexica Specify		Rican, etc.)		Black, W	/hite, et	c.
-003	hours tural",	ed by	XXWidowed	4 ☐ Divorced	Year	or Dates:	16	6a. Dece	dent's Usual Occur	pation			16b. Ki	ind of Busine		ite ustry
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7	ould be filed within Mental Hygiene. arked other than " atic event, the Ma	Jom m	Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Teacher									Education				
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)										Maiden Surname) ildred Canning			
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<u>စ</u> ်	is 1 and 2 is Health a item 27 is other trau		20a. Method of Dis		/ 3011		20h Place	of Disno	sition (Name of	-		ate		ocation - City		n, State
Бантішо	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.			☐ Cremation 5 ☐ Other (Sp		from State	Lak	etery, cren Ce V	natory or other pla iew al Par!	ce)	5/1	5/09	Syk	esvi	11e	, MD
a	permit. Departm Importa any inju once.		21. Signature of F	$\mathcal{A}\mathcal{H}$		<i>g</i>	1101	22	2. Name and Addre	ess of Facil						pel P.A.
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	/Medical Examiner		. vouling in abuili,	1	Du	e to (or as a c	onsequenc	ce of):	U							
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Ď,	e exe ian ar urial-ti	I Ex	resulting in death)	Last	Du	e to (or as a c	consequence of):									
0/00	cate b	edical		'	d										+	
o X	certiff iding se as	/Me	IF FEMALE:		23c. If yes	s, outcome of	pregnancy							23d. Date o	f deliver	v
Ď D D	death atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1										Month Day Year			
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0	ng Ph ter th neral	n:T	27. Manner of Dea	th 5 ☐ Pending		Date of Injury (Month, Day, Y		b. Time o	f 28c. Inju			28d. Describe				
SION	To the bropping of Attending Priystoan: The law requires that the beart certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	catic	2 Accident	investig	ation				M 1 🗆	Yes 2						
<u> </u>		Certification:									tion (Street and Number or Rural Route Number, or Town, State)					
_			29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	ne Ho n 24 } ne Fu pletel)	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										the cause(s)			
	Vithi Vom	ž										29d. Date signed (Month, Day, Year)				
			Nilon Ocher mo DO64957 may 10, 2009											od		
	12		30. Name and add	PATEL,						Timo	RE,	BALTI	mor	E,MI) 2	21215
	Sta		31. Date filed (Mor	oth, Day, Year)	1	32. Registrar's	Signature)						,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** April 13, Eleanor R. Perkins 9:45 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** College Manor Nursing Home Baltimore Lutherville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 11, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 😾 F Maryland 218-18-0414 84 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f sho event, it a Medical Examiner must be notified at Director 1 □Yes 2√□ No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Schnaper Drive 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 📉 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: black δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) marked other than College (1-4or 5+) 11O elevator operator supervisor department stores 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked oth Be Nevard Edward Cooper ဂ Anna Mae Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Perkins/spouse 3801 Schnaper Drive Randallstown, MD Department of Health Important: If item 27 any Injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 🕅 Donation 5 ☐ Other Specify) 3 ☐ Removal from State 21. Sign turn of Funeral Scholce Lice Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate the set (Final disease or conditions) Approximate Interval Between Onset and Death bstruct Chronic Line disease **Physician** uRs disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed the burial-trai resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical attending as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the detached ☐Yes 2 4No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, signt be c Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) this ctor: After thi 28b. Time of Frailib 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bolto. Md 21208 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:20 A M May 2009 Bruno Frank Paluch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 X M 2 □ F 21, 1924 Director 350-14-6748 85 April Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be neathed as 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20851 402 Calvin Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Paluch ည Anna Ptak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola R. Paluch/Wife 402 Calvin Lane, Rockville, Maryland 20851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 11, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2009 Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01548 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure Hours /Medical Due to (or as a consequence of): Examiner Pneumonia Day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe 2 No 1 □Yes 2 🛛 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral L 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d, Date signed (Month, Dav. Year) May 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Wei Zhang, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

9901 Medical Center Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 2009 0 John H. Ruffin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Northwest Hospital Center Randallstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec | 22, 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F 224-38-4394 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show the Medical Examiner must be notified at 1 Yes 2 □ No Director 28a-f Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 21213 USA 2007 North Washington Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Shop Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any lipiry or other traumatic event once. Be Unk. Ruffin Nancy Mickie ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2007 North Washington Street Baltimore, MD 21213 Joyce Ruffin, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/11/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee momas Gregor 22 Name and Address of Facility Of Maryland, Inc. Thoma 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** 4 h /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o, injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has l page 2 s autopsy performed r this certificate had rail director, page 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pleback MD

▶2. Registrar's Signature

and manner stated.

29c. License number

mail

29d. Date signed (Month, Day, Year)

may 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6,2009 M mq00: E Radhakrishnan May Ramaiah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15014 Blackburn Road Burtonsville Montgomery 8. Date of Birth

2/14/1935 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Days 74 India 219-25-6852 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Addeal Examiner must be notified at 28a-f shov Burtonsville MD Montgomery 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20866 15014 Blackburn Road Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Asian ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
1 2 College (1-4or 5+) Temple Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Krishnaveni Naidu Ramaiah ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 15014 Blackburn Road Burtonsville, Md 20866 Vasantha Radhakrishnan/ 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Demoval from State Chesapeake Crem. 5.08/2009 Beltsville, Md 4 Donation 5 □Other (Speci . Fµneral Service Li PHILIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia bLvd.Silver Spring, Md20910 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension, chronic obstructive pulmonary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? disease autopsy performed? 1 ☐ Yes 2 XNo To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 7,2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

5632 Annapolis Rd #10 Bladensburg, Md 20710 Ratkumar Bhojaj 31. Date filed (Month, Day, Year) Registrar's Signature MAY 1 2 2009 pare

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a col

D23181

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND, ITEM#IperPHYS, G891,5/12/09, WS

10b & 18 per FH G892 6/9/09 IT

Certificate of Death

Reg. No. 2 0 9 Amend 10b & 18 per For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Glenn Ridal Jr 2. Date of Death 3. Time of Death 2, 200 Month **Physician** 8:42F M /Medical A COV 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Sex 1 M 2 □ F Months Days Min. Hours Director 4-28-3399 June 26, 1935 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County **Baltimore** Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Pres 2 No Funeral Director 10e 10. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21083 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No No. 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No Nav 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify: Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 13 iinister . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Mary Baron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 1341 Hydes 21082 OYIS 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) cementaris 18434 21. Signature of uneral service License 22. Name and Address of Facility 1339 Movalle Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 E Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARREST /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and AORTIC ROOT ANEURYSM Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ≥ 2 No DIABETES 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 14 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 200 H 0058708 = W 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 OSLER DRIVE TOWSON MARYLAND 21204 FRANKEL D.O. 7601 NEAL R. 32. Registrar's Signature 31. Date filed (Month. Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State of Ma	aryland		artment <i>rtificate</i>			and Me		gien Reg. No	211119	15251
	Physici		1. Decedent's Name (First, Middle, Last) Olive W. Reynolds 2. Date of Death May 10 Day 2009ar										3. Time of Death 6:30p M		
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1159 Seneca Road Middle River Baltimon										Baltimor		
	Funeral Director		5. Social Security No. 215-05-	0339	1 □ M 2 X F	89	Yrs.		Days	Hours	Min.	B. Date of Bir (Month, Da March		1920	place (State or Foreign ntry) MD
	yland now		Usual Residence of 10a. State	10b. County		10c. City,	, Town or Lo	cation						1	0d. Inside City Limits
	he Mar 28a-f sl	Director	MD	Baltim	ore]	Middl	,					100 0	itizen of What Cou	1 □Yes 2 🔀No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventhes must be notified at	E Dir	10e. Street and Nun		10f. Zip Code 21 220						JSA	id y :			
980		by Funeral	11. Marital Status	Seneca ed 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:				gin? (Speci n, Puerto Ri	ify Yes or No can, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	n 72 ho "natur edical	letec		15. Decedent's E ify only highest gr	Education grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)				most of working			. Kind of Business/Industry	
	2 should be filed within n and Mental Hygiene. is marked other than "raumatic event, tro Men	Completed	Elementary/Secon		College (1-4or 5	5+)	Bookeeper							Church	
Maryland	l be file ed oth	Be		17. Father's Name (First, Middle, Last) Carroll B. Whittle									dle, Maiden Surname) n LLoyd		
aryl	should and Me s mark umatic	2	19a. Informant's Na							nd Numbe	er or Rural	Route Numb	er, City	or Town, State, Zij	
ě,	and 2 Health a				/daught					boc				ton MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus 5/14/09 Baltimore MD												
Ball			21. Signature of Funeral Service bicensee . 22. Name and Address of Facility 300 Mace Ave. Back Connelly Funeral Home of Esse												
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68760,		al Ex	resulting in death) L	ast	Due to (or as	Due to (or as a consequence of):									
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O. Box	at the death certific by the attending p tached for use as t	Physician/M	Part II. Other significant conditions continuously to death out not resulting in the underlying cause given in Part II.										d. Date of delivery Month Day Year		
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of Vital Records,	: The law requir cate has been s page 2 should	Completed										prior to co death?	opsy findings available ompletion of cause of 2 No		
Vita	Hospital or Attending Physician 4 hours after death. Funeral Director: After this certificibly filled in by the funeral director,	Be	25. Was case referr examiner? 1 ☐ Yes 2 ☐		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6								a 🗆 0 11 (a		
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Division		Certification:	2 Accident investigation 3 Suicide 4 Homicide determined 2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
^		Medical Ce	29a. Certifier (Check only) 29a. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a, perMD G891 5/12/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY 6, 2009 12:55 AM DANIEL JOSEPH REARDON III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours 1 □XM 2 □ F New Hampshire Director 215-84-1756 47 Sep. 8, 1961 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. orther If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Directo Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1835 Still Pond Way 21015 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced White event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Harford County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Electronic Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Daniel Joseph Reardon Jr. Sandra Jean Jameson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri B. Reardon / Wife 1835 Still Pond Way, Bel Air, Maryland 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Lutheran Cem: 5-9-09 Joppa, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
MCCOMAS Funeral Home, P.A. ly (un 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Esophageal Cancer-Metastatic** Immediate Cause (Final **Physician** disease or condition resulting in death) wellena /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, 5 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Cher (specify) certificate has been signed by the a rector, page 2 should be detached f □Yes 2□No 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeage Dr. Bel

State Registrar 31. Date filed (Month, Day, Year)

M0000089

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:15 1 4, Elizabeth 2009 MO) /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 110115 SXKESVILLE sichover 8. Date of Birth (Month, Day, Jan 31, If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1920 1 ☐ M 2 💢 F Arkansas 89 085-18-7620 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Sykesville MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 7200 Third Avenue A-203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) education librarian 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nettie Lynn Rowley Joseph Capers Baker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13805 Burntwood Road Glenelg, MD Charles Rouiller/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) ce Licensee Ae 22. Name and Address of Facility Signature of Funeral Servi State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Leon Immediate Cause (Final BILLE Congestive **Physician** Monins disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician the for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Director: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prev 295 onn (Appl MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 05 Year **Physician** 22:35 FM Fana Smith 07 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center Baltimore 8. Date of Birth Month Day, 5. Social Security Number 212-42 - 4081 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) Days Min Months 1 ☐ M 2 🔏 F Yrs Argland Director Usual Residence of Decedent 10b. County City Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Wedfool Exemitive to ust by notified at 1 Yes 2 No **Funeral Director** more 10f. Zip Code Street and Number 10g. Citizen of What Country? filed within 72 hours after death with CKer . Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify. aci Completed by 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) , bear , an Baltimore, Maryland 17. Fath Name (First, Middle, Last) er's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked o dra ဥ 19b. Mailing Address (Street and Number or Rural Route Number 5 20b. Place of Disposition (Name of cemelery, crematory or other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 🗆 Removal from State Injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any fr 9 23a. Part I Enter the cisease, or complications that caused the death. Do not enter the mode of dying, such as car fac or respiratory arrest shop, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Im nedia e Cause (Final di rease or condition r-sulting in death) Stroke CVA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760. Physician/Medical phys the nding p IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by sign be 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? page of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending F s after death. I Director: After d in by the funera 1 Natural Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05/07/2009 P22137 anell no

State Registrar ourtness

31. Date filed (Mounth, Day, Year)

DHMH 17 Rev 1/2001

22. S. Greene

22. Registrar's Signature

Baltimine.

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			1. Decedent's Name (First, Middle, Last)	Cert	ilicate of D		Reg. Date of Death	. No. 2 1 1 9	3. Time of Death
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edu.	/Medic		93		4b. City, Town, or L		ney	6 2009 4c. County of Deat	1.10
-	Examin	er	4a. Facility Name (If not institution, give street and number)		0 11		1.	io. County of Douc	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director		220-30-7202 10M 2KF 75	Yrs.	Months Days	Hours Min.	(Month, Day, Yo	1934 AL.C	AROLINA
	in magain		Usual Residence of Decedent				11 11 11 10		
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	e Ma 3a-f s	cto	MARYLAND N/A	BALT	MORE				
	er 28	Directo	10e. Street and Number		10f. Zip Code	0.5		. Citizen of What Co	untry?
	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. ad other than "natural"; or items 23a or 28a-f show do other than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at	ra	2420 LOYULA BOUTHWAY		210			J.S. F.J.	rican Indian
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in L Armed Forces?	J.S. 13. W.	as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Speci , Mexican, Puerto Ri	ry Yes or No- can, etc.)	14. Race - Ame Black, Whit	
0000	s after ", or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1[☐Yes 21 No	Specify:		Specify: 3	LACK
3	within 72 hours ene. than "natural"; he Medical Exa		15. Decedent's Education	16a. Decede	nt's Usual Occupat	ion	16	b. Kind of Business/	Industry
Ċ	in 72 n "na fedic	olet	(Specify only highest grade completed)	(Give ki		ring most of working			
7	with jene. r thar the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CD	SMET	01061	ST S	ELF EI	MPLOYED
2	e filed I Hyg other	BeC	17. Father's Name (First, Middle, Last)		1	8. Mother's Name (i	First, Middle, Ma		
a	should be nd Menta marked matic ev	10 B	JOE FRIDAY	5	7	RUBY		140	ES
ary	W = =		19a. Informant's Name/Relationship (Type. Print)		•	nd Number or Rural i			
	and 2 ealth a n 27 is		VALERIE A. FISHER (DAUGHTER	32420	LUYULA	SOUTHWA	Y, BALTI	MORE, MI	21215
ה	es 1 a of Heg		# Duniel Officemetics Officement from State		atory or other place,		/	c. Location - City or	Town, State
baltillino	permit. Pages Department of Important: If it any Injury or o once.		4 Donation 5 Other (Specify)	DODLA	UN CEME	TER 05/12/	2009		
ā	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee	22.	Name and Address	of Facility	JR.FU.	NERAL H	OME
<u> </u>	89 = 89		which N. Willian	21.	40 N. FUL	TON AVE	121461	ITTORE	ND 21217
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not enter	the mode of dying,	, such as cardiac or	respiratory arrest	t,	Approximate Interval Between
44	Physician		Immediate Cause (Final disease or condition	1516	A:sease				Onset and Death
١.	/Medical		resulting in death) Due to (or as a consec	quence of):	D. 30-3-				
	Examiner		Sequentially list conditions. b.						
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):					
	ecute and trans	(am	Causs (Uiscass or injury that initiated events resulting in death) Last Due to (or as a consecution of the	guenne of):					
00,	te be executed ysician and he burial-transit		Due to (or as a conser	quesice oi).					
-	cate I	dical	d						
XO	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregr	nancy				23d. Date of de	liven
0	atten for us	ian	in the past 12 months?	tal death 3 🗆 🛭	Ectopic pregnancy Other (specify)			Month	Day Year
j	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	death 5	Other (apecity)				
7	requires that the een signed by th nould be detache	된	Part II. Other significant conditions contributing to death but not re-	sulting in the unc	derlying cause giver	n in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
S	uires sign d be	d by					1 ☐ Yes	2 No 3 P	robably 4 🗗 Unknown
cords	v requestions	Completed					24a. Was an	24h Were a	utonsy findings available
d)	The law ate has b	m					autopsy	ed2 death?	utopsy findings available completion of cause of
	n: TI ficate rr, pa		25. Was assa referred to modical			00 Disease f Darette			s 2□No
5	ding Physician: The lav n. After this certificate has funeral director, page 2	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	TER/Outpatient	l Other	26. Place of Death (ce 6 □Other (Spe	a giful
5	Phy r this ral d	은 -	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury	at 28	d. Describe how		еспу)
0	ndIng th. : Afte e fune	ţi	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	M Vork?	es 2□No			
VISION	Atter dear ector by the	fica	3 Suicide 6 Could not be 28e, Place of injury - At h	nome, farm, stre	et, factory, office	28	f. Location (Stre	et and Number or F	ural Route Number,
5	al or s afte	Certification:	4 Homicide determined building, etc. (Spec	пу)			City or Town,	Siale)	
	ospit hour: unera ly fille		29a. Certifier 1 Certifying Physician: To the best of my kn (Check only 2 Medical Examiner: On the basis of examin	owledge, death	occurred at the time	e, date and place, ar	nd due to the cau	use(s) and manner a	s stated.
)	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one) Medical Examiner: On the basis of examiner one) and manner stated.	and and inv					
J	To t To t	Σ	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (Mon	th, Day, Year)
L			M.6.		059	062		May 6,	2009
			30. Name and address of person who completed cause of death (Ite					•	
			Chad J. Hansun, M.D. 2	401 W	Belvede	· Balk	mor ML	21215	
	Sta		31. Date filed (Month, Day, Year) MAY 1 2 2009 MAY 1 2 2009 MAY 1 2 2009	lature Manual	1				
	Registr	GI.	MAY IZZUUU ZIMMAN P.	Man care					

DHMH 17 Rev 1/2001

Patient Known as Betty K Jolomon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 110 M 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 7: monium
If Under 1 Year | If Under 24 Hrs. May Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Funeral Days Months Hours 241-68-6994 1 MM 2 □ F Director 65 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examirer must be notified at once. 10d. Inside City Limits 1 Nes 2 No Funeral Director na MULL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 501 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by 3 ☐ Widowed 4 🔀 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 5255 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colli Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau × on each line. Immediate Cause (Final disease or condition resulting in death) Physician LARYNX CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 ☐ Yes the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\Bigcap \) Nursing Home \(5 \Bigcap \) Residence \(6 \Bigcap \) Other (Specify) \(\bar{HOSPICE} \) 1 Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital o 24 hours aff e Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practitioner error stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

SESSION

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Carolyn Garthwait Smaltz 10 2009 10:30 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Ginger Cove Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 02/18/1926 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1□M 2□F Months Days Hours Indiana 316-22-4267 83 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 River Crescent Drive 21401 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Garthwait Golda Jefferies 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Smaltz Bellomo/Daughter 3141 Catrina Lane, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services | 05/12/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services HardesTy Zama M01197 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-stage with agitation YRar) Due to (or as a consequence of) Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at

al Hygiene.

permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evone.

Completed by Funeral Director

Be

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ited within 72 hours after death with the Maryland

bet i and Mental

Baltimore, Maryland 21215-0036

burial-transit ned by the ettending physicien detached for use as the buria Physi cete has been signed, page 2 should be dei

Physicien: The law requires that the death certificate be executed

certificete

this

Director: filled in by the

within 24 hours e To the Funsrel D

Hospital or Attending

death.

Division of Vital Records, P.O. Box 68760,

Examiner

ician/Medicai

þ

Completed

Be

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Certification:

Medicai

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical examiner?

31. Date filed (Month, Day, Year)

t ☐ Yes 2 No

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed 1 Yes 2 No

2□ No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Tyes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

D 0029571

29c. License number

son who completed cause of death (Item 23a) (Type, Print) 2225E Defense Hwy, Crofton, MD 21114

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylai		artment of F		_	giene Reg. No. 2 0 0	9 15258
4	Physici /Medio		1. Decedent's Name (First, Middle, Last) ROBERT	J.	^	ITH	-	2. Date of De	ath Day Year	3. Time of Death
A STATE OF THE PARTY OF THE PAR	Examin	er	4a. Facility Name (If not institution, give si The Johns Hopkins Hos			4b. City, Town, or Baltimore	Location of Death	,	4c. County of Dea	th
4	Funeral Director		5. Social Security Number 6. Sex 218-28-0812	·	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/02/	th y, Year) 9. Bi Co L934 Mar	thplace (State or Foreign wintry) yland
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltimore 10e. Street and Number		ity, Town or Loc	cation 10f. Zip-Code			10g. Citizen of What Co	10d. Inside City Limits 1 🗶 Yes 2 □ No puntry?
	tth with 23a o		13035 Long Green	Pike		21082			U.S.A.	
920	urs after dea al", or items xaminer mu	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in the Armed Forces? Yes 2 □ No If Yes, Give Year or Dates: 		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🙀 No	lispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		
1215-0036	within 72 hound in 12 hound in	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	dent's Usual Occup kind of work done DO NOT use retired	during most of wor d)	king	16b. Kind of Business	s/Industry -
Maryland 2121	uld be filed v fental Hygie rked other i ic event, th	To Be Co	17. Father's Name (First, Middle, Last) Philip Smith		<u> Debt</u>	COTTECT	18. Mother's Nar	me <i>(First, Middle</i> et Parke	, Maiden Surname)	
Mary	id 2 shou Ith and N 27 is ma traumat		19a. Informant's Name/Relationship (Type Sandy Riedal/Daug	*					er, City or Town, State, ill, Maryla	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er once.		20a. Method of Disposition 1 □ Burial 2 💆 Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	I (Otete	cemetery, cren	sition (Name of natory or other place mation Serv	vices 05/1	Date 2/2009	20c. Location - City o	
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Licensee						remation Se .N, Hanover	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	cations that caused the dealer cause on each line.	cquence of):	er the mode of dying		c or respiratory a	rrest,	Approximate Interval Between Onset and Death
760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conse	equence or):					
P.O. Box 687	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of preg 1	tal death 3	Ectopic pregnand Other (specify)	ey		23d. Date of d	elivery Day Year
	The law requires that the te has been signed by the page 2 should be detach	þ	Part II. Other significant conditions con	tributing to death but <i>n</i> ot re	esulting in the u	underlying cause g	iven in Part I.	23e. Did t	tobacco use contribute Yes 2 \(\subseteq \text{No} 3 \(\subseteq \text{F}	to the cause of death?
Records,	The law red ate has beel page 2 sho	Completed						24a. Was auto perfo 1 Yes	an 24b. Were a prior to death?	
Vita	ysician: The I s certificate ha director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1X Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	26. Place of Dea	th (Check only only only only only only only only		ecify)
Division of Vital	ling Phy n. After this funeral	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injui Wor	ry at		how injury occurred	
Divis	al or Attendi s after death. Il Director: A ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At I building, etc. (Spec		eet, factory, office		28f. Location City or Tox	(Street and Number or I vn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical (iclan: To the best of my kn er: On the basis of examir and manner stated.						
)	To the within To the comp	Me	29b. Signature and title of certifier	,MD		29c. Licens	e number	00	29d. Date signed (Mor	
			30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print)				

State Registrar

600 North Wolfe St, Baltimore, MD, 21287

/Medical **Examiner** Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, K

attending physician the the þ signed b has this certificate s after dea... eral Director; A'... v filled in by the within 24 hours a

To the Funeral D completely

Physician

/Medical

Examiner

Director

Funeral

<u></u>

Be Completed

ပ

Examiner

Physician/Medical

þ

Be Completed

Certification: To

Medical

31. Date filed (Month, Day,

Funeral

Director

id other than "natural" or items 23a or 28a-f show event, the Medical Exeminant, ust by notified at

permit. Pages 1 and 2 shot ld be filed witl Department of Health and Mental Hygient Important; if item 27 is marked other the any injury or other traumantc event, the Jones.

Physician

hours after death with the Maryland

			performed death? 1 Yes No 1 Yes 2 No
25. Was case referred to medical		26. Place of Death (C	heck only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		28c. Injury at Work? 1 Yes 2 No	Describe how injury occurred
3 Suicide 6 Could not b		ctory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occu miner: On the basis of examination and/or investig and manner stated.		I due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
29b. Signature and #tle of certifier		29c. License number	29d. Date signed (Month, Day, Year)
V////	711/2	057361	5/10/09

Towson MD 21204

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Year Physician 5:42 AM Sukhitanon assachol 05 2064 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UMMC Rult invre 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 17, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Thailand Days Hours 1 □ M 2 🗓 F 33 Yrs 220-69-5738 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2517 South Paca Street 21230 Thailand Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: Specify: Asian Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilas Kanaderm Paka Watanachai ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2517 South Paca Street Baltimore, Maryland 21230 Somehok Sukhitanont, Husband Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory Inc. 05/11/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightsee Thomas Gregor Pame and Address of Facility Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hepotitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 🖾 No 1 ☐ Yes

or Attending Physician: The law requires that the death certificate be executed Box 68760点 P.O. Division of Vital Records, after death.

Certification: To

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

4 Homicide

ochen

3 ☐ Suicide

To the Hospital within 24 hours a To the Funeral C

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1588823827 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

1 ☐Yes 2 ☐No

1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

Medical

Steppan

Hospital:

5 Pending investigation

6 ☐Could not be determined

Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T - For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 11:17 AM oris 2009 MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2-22-1931 Birthplace (State or Foreign Country) . Age (In vrs. last birthday) Days 1 M 2X F 213-26-8968 Yrs 78 N.C. Usual Residence of Decedent 10d. Inside City Limits 10a State 10h Chunty 10c. City, Town or Location 1 ¥Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 1700 N. Gay Street USA 21213 Apt 216 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: % Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) March Funeral Home 12th grade 17. Father's Name (First, Middle, Last) Floral Designer Year 18. Mother's Name (First, Middle, Maiden Surname) Jarris Howard Telsie Bailev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gaynell Colburn-Daughter 1700 N. Gay Street Apt 216 Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King MemorialPark 5-9-2009 Randallstown. MD 21. Si Juliura of Funeral Service Licensee 22. Name and Address of Facility March East F/H Lauch 1101 E. North Avenue Balto, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRITURY HYPOXIC HOUR disease or condition resulting in death) Due to (or as a consequence of) PRESUMPTIVE PULMUNARY HOURS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injury thad injury that injury that injury that injury that injury that in Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Tyes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 3 🗆 DOA

Physician /Medical **Examiner**

attending

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certificate

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or Attending After

Hospital 24 hours

within 2

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

or items

"natural",

and Mental Hygiene. is marked other than

Health tem 27 i

Department of

Important: If item 2 any injury or other t

the Medical

filed within 72 hours after

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

Examiner must be notified

Director

Funeral

by

Completed

Be

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Examine physician and as the burial-trans Physician/Medical use as t ģ pe Completed page Be မ funeral ع spital د. 4 hours after de.. مeral Director, After ات by the fu

Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Certification:

1 🗌 Yes 1 Natural

29a. Certifier

2 No 27. Manner of Ceath

2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of (Month, Day Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2 No

6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

2009

MAY

State Registrar

Medical

M.D 31. Date filed (Month, Day, Year)

min.



09-03653 James Schaffer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15262 2009 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month D. May 6, 2009 1556 hrs Medical Examiner James Leroy Schaffer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 4373 Nicholas Avenue 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreignaryland Months Days Hours Min 060-44-7509 54 Director 195 17 1 X M 2 F Vrc Usual Residence of Deceden 10d. Inside City Limits 10c. City. Town or Location iny 10a, State 10b. County 1 X Yes 2 No Baltimore 23a or 28a-f show notified at once. N/A Maryland imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygone.

aut. If item 27 is anarked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. irector 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 21206 4373 Nicholas USA Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Mantal Status White, etc Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 1 X Yes Black Divorced If Yes. Give Year Yes 2 X No specify: Widowed ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Painting Industry Laborer 10th grade 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Leroy Schaffer, (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 204 Seagull Michael Schaffer/ Son Ave Cherry Hill Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a Method of Disposition Saltimore, Aent of H 5/15/09 crematory or other place) 1 XBurial 2 Cremation 3 Garrison Forest Vet.Cem. Owings Mills,Md Donation 5 Other Specify 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature Funeral Service Licens Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line 'Medical Death Atherosclerotic cardiovascular disease Immediate Caux (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and trans. Physician/Medical AMENDED 23a, PII, 27, perME, g892 6/15/09 TT ysician a burial -X UNPENDED Box 68760, attending phys for use as the bu 23d. Date of delivery IF FFMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0 <u>۾</u> Probably 4 V Unknown Yes 2 No 3 Cirhosis Completed Records, certificate has been sector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No ✓ Yes 2 1 1 Yes After this certifi-funeral director, 26.Place of Death (Check only one 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other₄ Nursing Home 5 __ Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Inpatient 1 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death ication: 1 X Natural Pending Yes 2 Director: 24 hours after death. 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. May 7, 2009 30. Name and address of per on who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 31. Date filed (Month, Day, Year) __ -32 Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5:30 pm May 10, 2009 Patricia Ann Somogyi 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FSSEX
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Baltimore 1501 Somogyi Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🛣 F Yrs Maryland 220-28-3803 1/1/1933 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S. 21221 1501 Somogyi Road U. Α. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) E. <u>Catherine</u> Noraine Shook Fraley George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1501 Sourceyi Road Essex, Maryland 21221
ce of Disposition (Name of Date 20c. Location City of <u>John Somogyi (Husband)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/14 2009 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lichart Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 Weeks Sepsis Due to (or as a consequence of): 2 Years Diabetic Ulcers Sequentially list conditions, if any, learning to introducts cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 15 Years Diabetes Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an History of Cervical Cancer autopsy 1 Yes 2 No 1 Yes 2 XNo 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ed by the cete has been signed , page 2 should be def certificate has or Attending Physician: After this certific funeral director, death. within 24 hours after death To the Funerel Director: / completely filled in by the f

Physician

/Medical

Examiner

Director

Funeral

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be tiled within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.
Important: If itam 27 is marked other then "naturel", or items 23a or 28a-f show any njury or other traumatic event, the Wadical Examiner must be notified at once.

Physician

Baltimore, Maryland 21215-0036

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 | Homicide

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified TiN

6 Could not be determined

005134

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9101 Franklin Square Drive Suite 205 Baltimore, Maryland 21237 31. Date filed (Month, Day, Year)

State Registrar



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** .55 P^M Clarence Edward Smith Мау 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Towson Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □MM 2 □ F Director 2-4-1940 217-38-2020 VA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ns 23a or 28a-f show 1 □Xes 2 □ No Director Baltimore MD Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 101 Center Place, Funeral 21222 Apt. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☑ No 14. Race - American Indian. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any injury or other treumatic event, Ite Moulcal Examinations. Black, White, etc. filed within 72 hours after 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 □ No Specify à Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Service Station Gas Station Attendant Service
18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willis Theodore Smith, Sr. Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Earl Smith - Brother MD 21236 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5-9-09 Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** COLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ☐ Yes 2 No 3 Probably 4 Unknown SMITH Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate mneg? 2∭No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 Σ Other (Specify) HOSPICE Hospital: 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical oneX Nurse Practitionemer stated. 29c. License number 29d. Date signed (Month, Day, Year)

3 V

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY WALLEY

2 20

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 1:19 Carl Eugene Stoner May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1**⊠** M 2□ F MD 5-3-29 80 Director 214-28-5895 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Mwitcel Exemires must be notified at 1 ☐ Yes 2 🔀 No Westminster Director Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2210 Ridge Rd. 21157 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales 12 Meat Cutter of Health and Mental Hygien fitem 27 is marked other the rother traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Mary Emma Stansbury Clayton Lee Stoner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a:
Important: If item 27 is
any injury or other trau 2210 Ridge Rd. Westminster, MD 21157 Margaret A. Stoner-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Method of Disposition

1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State
A 1 ☐ Charles (Spacify) County Cremation 5-7-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, 21. Signature of Funeral Service Licensee Chomes D. 254 E. Main St. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 days **Physician** KESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): BACTERIAL BRONCHITIS WEEK Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE EARS Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 THes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate ha 1 ☐ Yes 2 TH 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tinpatient 1 | Yes 2 PNo 2 ER/Outpatient 3 DOA Certification: To 27. Manner eath Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier 29246 30. Nat e av address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

MD 32. Registrar's Signature

WASHINGTON HEIGHTS

09-02889 Dayon L Scott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 15266

			- For State	Certific	tificate of Death				Reg. No.								
Phy	/sicia	Registrar 1. Decedent's Name (First, Middle,Last)											Date of Month	Da		r	3. Time of Death 0058 hrs
edical Ex	kamir	ner	Dayon L. S	cott	:								April 1	, 200	9 4c. County c	-f Dooth	
		4	a. Facility Name (if not instituti Johns Hopkins Hospi		street and nu	mber)		4	b. City, To Baltimo	ore							
Fun	eral		5. Social Security Number	6. Sex	(7. Age (In	yrs. last bi	rthday)	If Under		If Under Hours	24Hrs. Min.		,		9. Bir	thplace (State or Foreign Maryland
Dire	ctor		infant	1X	M 2 F			Yrs.	Months	149 ^{ys}	Hours	IVIII I.	Feb	19,	2009	<u> </u>	Maryland
		Ė	Usual Residence of Decedent														10d. Inside City Limits
	any		10a. State 10b. County			100	. City, Tow										1X Yes 2 No
pu	show nce.	5	MD					Balti									
_ e	or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 705 Woodbou	rne	Avenu	е			10f. Zip (Code 21218	3			10g. Citizen of What Country? USA			
with th	s 23a		11. Marital Status		12. Was De		er in U.S.	13. Wa	s Deceden es, specify	t of Hisp	anic Origi	n? (Spe	cify Yes	r No-		e - Amer	rican Indian, Black,
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21215-0036 ould be filed within 7 Mental Hygiene.	rked ent,	a	the Mailing Address (Chest and Number of Pur									ural Pout	. Numbe	or City or Toy	wn Staf	te Zin Code)	
ore, MD 21215-003 es 1 and 2 should be filed withi	tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	۴	19a. Informant's Name/Relation	. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 111 Penn Street Baltimore, MD 21201									_	.o, 21p 0000)			
MD nd 2 sho	n 27 auma		O.C.M.E.				20b. Place					LTI	nore,		2120 20c. Location		or Town, State
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Baltimore, permit. Pages 1 ar Department of Hea	Important: injury or oth	1	21. Signature formeral service Licensee de, Director 22. Name and Address of Facility tate Anatomy Board 655 W. Baltimore Raltimore MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart													Street	
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Division of Vital Records, P.O.	ours after death. reral Director. After this certificate I filled in by the funeral director, page	Certification:	3 Suicide 6 X C	ctermine	t be		nouse						Ba ^{or}	iown, Si :imo	re, MD	WOO	Jabourne Av
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi	within 24 hours after death To the Funeral Director: completely filled in by the	၂ဝ	4 Homicide 29a. Certifier 1 Certifyin	Physic	cian: To the	best of my	knowledge.	, death occ	urred at th	e time, d	ate and p	lace, an	d due to t	ne caus	e(s) and man	ner as s	stated.
the H	within 24 h To the Fun completely	edical	(Check only one) 2 Medical	Examine	er: On the bas	is of exam	ination and	or investig	ation, in m	ny opinio	n, death o	ccurred	at the tim	e, date a	and place, an	d due to	o the cause(s)
To	To the	Med	29b. Signature and title of ce		and manne	er stated.					se numbe						(Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 7:04 P M Schumann 8 2009 Albert Frederick May 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 1 ☑ M 2 ☐ F 79 2, 1929 NY 034-24-7475 Dec. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2√∑ No Towson Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 258 Ridge Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify: 3 ☐ Widowed 4 🕅 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aero Space Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Frances DeCelle Frederick C. Schumann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 101 Nob Hill Park Drive, Reisterstown, MD 21136 Stephen F. Schumann Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/15/09 Owings Mills, MD Garrison Forest Vet 22. Name and Address of Facility 11824 Reisterstown Road Meins Reisterstown, MD Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): EPTIC SITOCK Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a conse wence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

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Completed

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modosil Exprises, cut be notified as once.

certificate After this

Physiclan/Medical ò Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the 5

State Registrar

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗽 🕠 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 K No 1 ☐ Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

V,CharlesStSTESSO

25. Was case referred to medical examiner?

5 ☐ Pending investigation

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Cei	rtificate of L	Death	•	Reg. No	09	15268
			1. Decedent's Name (First, Midd	dle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Peter	Sunday	Sr.			MAY	10	2009	@1:15AM
	Examin		4a. Facility Name (If not institution	on, give street and number)		'4b. City, Town, or	Location of Death		4c. Cour	nty of Death	
			Northwest H	ospital			lal1stown			Baltin	
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	ı <i>y, Year)</i>	Counti	ace (State or Foreign ry)
	Director		214-20-4249	11√2 M 2 □ F {	32 Yrs.			March :	2, 1927	7 New	York
	pu >		Usual Residence of Decedent 10a. State 10b. Count		10c. City, Town or Lo	scation				10	d. Inside City Limits
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212	within 72 ho iene. than "natur	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired))	king			
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2	be file ntal Hy sd oth event	Be (17. Father's Name (First, Middle	e, Last)			18. Mother's Nam	ne (First, Middle	, Maiden Surr	iame)	
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9			20a. Method of Disposition 1 5 Rurial 2 □ Cremation	3 ☐ Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	e)	Date		on - City or Tov	
Ē	Pages Iment of tant: If its jury or o		4 ☐ Donation 5 ☐ Other (Specify)	Lake View			5/09	Sykes	ville,	Maryland _
Baltimore, Maryland 21215-0036	permit. Page Department Important: If any Injury or once.		21. Signature of Furnital Service	Licensee	V^{2}	2. Name and Addres	ss of Facility 11	.824 Rei	sterst	own Roa	ad
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ב	ing F	ö	27. Manner of Death 1. Natural 5 □ Pend		/ 28b. Time of Injury	Worl		28d. Describe	how injury oc	curred	
200	tend leath tor: /	cat	2 Accident Inves 3 Suicide 6 Coul	tigation	At home form of		Yes 2□No	28f Location	(Ctroot and N	umbor or Pura	I Route Number,
Division of	or Ag after of Direction by	Certification: To	4 ☐ Homicide deter	mined building, etc.	y - At home, farm, st (Specify)	reet, lactory, office		City or To	wn, State)	Jinber of Hora	riodic rumbor,
	spital ours eral filled		29a. Certifier 1 Certify	ring Physician: To the best of	my knowledge, dea	th occurred at the ti	me, date and place	e, and due to the	e cause(s) an	d manner as s	tated.
	e Hos 24 h e Fun letely	ledical	(Check only 2 Medic	al Examiner: On the basis of and manner state	examination and/or i	nvestigation, in my o	ppinion, death occi	urred at the time	, date and pla	ce, and due to	the cause(s)
	To the Hospital or Attending Physician: whin 24 hours after death as the Funeral Director: After this certifica completely filled in by the funeral director; to	Me	29b. Signature and title of certif	ier	2	29c. Licens	e number	7	29d. Date si	gned (Month, i	Day, Year)
			Y),		m D	D	1401	1	May	, 10,	1009
	140		30. Name and address of person	on who completed cause of de	ath (Item 23a) (Type	, Print)		2 (1	7/		
١	10		Oary 17	on who completed cause of de process of the process	2	- ma	inst	211.	56		
	Sta	_	31. Date filed (Month, Day, Yea	7) 32. Projištrau	rs Signature	6 4 1					
	Registi	ai	西八丁 上	& ZUUY Leven	N B. A	auto					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2009 11 5:54A May SUSAN ELLEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country)

March 27,1940 Maryland Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 69 220-40-7717 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Marical Exprision out to incline any once. 1 □Yes 2 □ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 USA 421 Chumleigh Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes X2X No Specify: \$ 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Francis Wilkinson Frances McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DTR Susan Theresa Ayres 3406 Grier Nursery Road Street, Maryland 21154 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State GreenMount Crematory | May 14,2009 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Familytchell-Wiedefeld Funeral Home Inc. ature of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. RI NOULSE 29d. Date signed (Month, Day, Year) 29b. Signature and file of certifier

State Registrar person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** 20°09 AURIN C. TIMMONS 1:58 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Hebrew Geriatric Ct. NA Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 € M 2 🗆 F 247-26-6104 SC Director 90 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD NA BALTIMORE 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2314 N. Rosedale Street 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH NA Custodial Supervisor B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Timmons Ella Harrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 N. Rosedale St. Baltimore, MD 21216 Alice Pearl Timmons -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dickfield Cem. 05/18/09 Cartersville, SC 4 Dqnation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 21. Si 4300 Wabash Ave. March Funeral Home West, Inc. Balto., MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 I Inknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 2 X No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform Yes 2 certificate 1□ Yes Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only onle 1 ☐ Yes 2 🗚 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient this 27. Mapper of Sath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the Funeral Directory that filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation in examination and the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the 29a. Certifier Medical

State Registrar 29b. Signature and

31. Date filed (Month, Day, Year)

MAY 1 2 2009

30. Name

DHMH 17 Rev 1/2001

within 2

and/manner stated.

32/ Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:18 P.M Physician 2009 John Trail /Medical 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk If Under 1 Year Months Days 8. Date of Birth (Month, Day, Yea, Feb 22, 1 Number 6. Sav 7. Age (In yrs. last birthday) **Funeral** Hours 1 ₹ M 2 □ F 219-42-3262 64 1945 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Department if item 27 Is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Evertine 1 with the Loude.
any injury or other traumatic event, the Medical Evertine 1 with the Loude.
once. Yes 2 No MD Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10 N. Rock Glen Road 21229 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 900 S. Caton Avenue Baltimore, MD 21229

of Disposition (Name of Date 20c. Location - City or Town, State St. Agnes Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Dother (Specify) in state 22. Name and Address of Facility 21. Signature of Jun and Service Licensee Ronal & Wade rector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23d. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca Final disease or condition resulting in death) Physician inknown Arteriscleratio Vascular a. Due to (or as consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last That I if it is a consequence of: Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate I 2 2No 1 ☐Yes 2 ZNo Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2□No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natura! 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. Funeral Director: A 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar Homital

900 Caton Avenue Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Agnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Earl E. Thomas 5:30 P M 2009 May 8, /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Summit Park N & Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 6 / 2 3 / 1 9 2 7 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1[XM 2□ F Director 219-20-8616 81 Yrs Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show ither must be notified at 1

Yes 2□No Director MD n/a Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 314 S. Smallwood Street 21223 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 r than "natural", or 1 □Yes 2 No White Specify 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 City Government 0 <u>Maintance Eng.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 Is marked otl Herman E. Thomas, Sr. Mary V. Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Rev. Harold W. Brittingham/nep 330 Reams Court, Westminster, Maryland 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Pk. 5/12/2009 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TRACT INFECTION WITH SEPSIS **Physician** URINARY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ ARTERY CORONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPOTHYROLDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000

State Registrar HASAN

31. Date filed (Month, Day, Year) NAY 1 2 2009

DHMH 17 Rev 1/2001

Darke.

HAMMONDS

FERRY RD

BALTIMORE, MD 21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AWAN

2717

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** HARLES /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL UNION MEMORIAL 8. Date of Birth (Month, Day, Year)

APRIL 21, 1935

N. CAROLINA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Months Hours 245-50-8912 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director BALTIMORE MARYLAND 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number EUTAW PLACE, APT. 1012 "natural", or items 23a Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 XWidowed 4 □ Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) BANK OF AMERICA SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HENRY LEE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 EUTAW PLACE, APT. 1012, BALTIMORE, MD 21217 MARIE E. GETER (FRIEND) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 05/14/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses WAR 2140 N. FULTON AVE, BALTIMURE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Disease **Physician** Stage 5 years /Medical Due to (or as a consequence f): Examiner Pertension Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed DEPSIS burial-trar Due to (or as a consequence of): physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate has al director, page 2 s 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Director: After that in by the funeral 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Within 24 hours are.

To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

Adaku 6

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

32. Registrar's Signature

asade le

2009

29c. License number

inon Hemoria

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ For	Partment of Health and N Pertificate of Death		g. No. 2009	15274
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
· w	/Medic	al	Theodore Wiechman Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May	9, 2009 4c. County of Death	9:00 A ^M
	Examin	er	621 Fernhill Road	Curtis Bay		Anne Arun	del
ĺ.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, APR 11,	Year) 1944 9. Birthp Coun Mar	lace (State or Foreign try) yland
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State	Curtis Bay		11	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28a	ral Director	10e. Street and Number 621 Fernhill Road	10f. Zip Code 21226	10	g. Citizen of What Coun USA	try?
5-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, I'm Medical Enginer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1968- 14es, Give Year or Dates: 1971	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto □ Yes 2√√√No Specify: 	ecify Ye's or No- Rican, etc.)	14. Race - Americ Black, White, e Specify: Whi	etc.
1215-0	ithin 72 ho ne. han "natu Medical	Completed	(Specify only highest grade completed) (GElementary/Secondary (0-12) College (1-4or 5+)	acedent's Usual Occupation live kind of work done during most of work le. DO NOT use retired) Steel Worker	ing	6b. Kind of Business/Ind Sethlehem St	
d 21	should be filed within of Mental Hygiene. marked other than matic event, In Mental Hygiene.	CO	12 17. Father's Name (First, Middle, Last)		e (First, Middle, M		ree1
an	~ = 0 <	To Be	Herman Vincent Wiechman	Mae	Victoria	Stansbu	ıry
Maryland	2 should and Mer is marke raumatic			ailing Address (Street and Number or Run			′
	1 and 1 Health			Narragansett Trail		on, ME 0409 oc. Location - City or To	-
nor	Pages nent of h int: If ite		11 I Burial 2 N.B. remation 3.1 I Bemoval from State 1	sposition (Name of crematory or other place) rematory, Inc. 05/1		Baltimore,	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licensee George MacNabh	22. Name and Address of Facility Cre	emation S		
<u> </u>	9 3 2 6 8		Sery EMONTH	299 Frederick Roa		timore, MD	21228
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	enter the mode of dying, such as cardiac)13eA3.0	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
68760, %	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last Due to (or as a consequence of):				
			IF FEMALE:				
.О. Вох	The law requires that the death cert tee has been signed by the attending age 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to ths 2 □No 3 □ Prob	ne cause of death?
Il Records,	sician: The law requ certificate has been irector, page 2 should	Completed			24a. Was an autopsy perform 1 □Yes 2	prior to co	psy findings available mpletion of cause of 2 No
Vital	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Other:	h (Check only one		
0	g Phy: er this eral di	n: To	1 Yes 2 No	e of 28c. Injury at	28d. Describe how	nce 6 Other (Specified of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following	y)
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	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, companient on the basis of examination and/or and manner stated.				
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•	8+1		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	meri	ica 2	1035
Ĭ,	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and the second			•

		Pleas	e Type or Print in State of Maryla				-	_	gible.	
		For State Registrar	State of Maryle		ertificate of			Reg. No. 2	200	15275
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Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	or Location of Death	_		nty of Death	
		Gilchrist Ho			Towso				timo	
Funeral		5. Social Security Number 6 214-18-9318	1 □ M 2 5 E	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th <i>y, Year)</i>	g. Birth	place (State or Foreign ntry)
Director		Usual Residence of Decedent	93	115.			8-11-1	1915	M	D
rland		10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
Mary Include	ģ	MD Harfo	ord A	bingdo	n					1 ∐Yes 2X No
h the	Director	10e. Street and Number	TG A	DINGGO	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
ous after death with the Marylan urs after death with the Marylan al" or items 23a or 28a-f show	a E	3706 Swift Ru	n Court		2100	9		US	A	
items	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. R	ace - Ameri lack, White,	
or it	by Fi	1 Never Married 2 Married	If Yes, Give		1 ☐Yes 2 XXNo	Specify:			oify: Wh	
72 hours "natural"		3 ☐ Widowed 4 ☑ Divorced 15. Decedent's	Year or Dates:	16a Dece	edent's Usual Occur	nation	1	16b. Kind <i>o</i> f	Business/In	ndustry
i within 72 ho giene. r than "natu	Completed	(Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	during most of worked)	ing	105. 14.110	Daoin ooo, ii	, dudity
d with giene rr tha	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)	C	andy Pa	cker		Miss	Amer	. Candy
be filed within 72 hours after death with the Maryland tall Hygiene. Additional death with the Maryland of other than "natural", or items 23a or 28a-f show event, the Medical Examination must be modified.	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Name	e (First, Middle,	Maiden Surn	ame)	-
Ment Ment arked	၉	Phillip Wagne	r			Katrina	Louis	a Bru	nig	
2 shc and is m		19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ing Address (Street	t and Number or Rur	al Route Numbe	er, City or Tow	vn, State, Zi	p Code)
permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If tem 27 is marked other than any injury or other traumatic event, Its. Its once.		Marvin Warble	sr Son	370	6 Swift	Run Cou	rt, Ab	ingdo	n, M	D21009
ages 1 nt of h		20a. Method of Disposition 1 □ KBurial 2 □ Cremation 3	☐ Removal from State	cemetery, cre	ematory or other pla	ice)				
it. Pe irtmel irtmant injury		4 □ Donation 5 □ Other (Spe			ill Ceme	etery 5-	11-09	Middl	e Ri	ver, MD
permi Depa Impo any ir		21. Signature of Funeral Service Lie				Br				neral Home
		23a. Part 1. Enter the disease, or co	emplications that caused the d	leath. Do not en	134 Will	low Spri	ng Roa	td, 21	222	Approximate
Physician		shock, or heart failure. List or Immediate Cause (Final	ly one cause on each line.	21-22	1					Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	ug					UMUS
Examiner		Conventially list conditions	Antai	al tri	mullers!	1				Days
p ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):						
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leath certificate attending physic for use as the lead	sician/Medic		d							
anding use a	n/M	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. I	Date of deliv	very
death e atte	icia	in the past 1 V months? 1 □Yes 2 X No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		☐ Ectopic pregnand ☐ Other (specify) _	cy			Month	Day Year
at the by th tache	Phys	9 ☐ Unknov(n	g ☐ Unknown							
The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	by F	Part II. Other significant conditions	s contributing to death but not	resulting in the u	underlying cause gi	ven in Part I.				the cause of death?
requii	Completed	Coronaldin	790000	1.01001.	E 107 /10	719	1 🗆	Yes 2 □ No		
e law has b	nple						24a. Was	psy	b. Were aut prior to codeath?	opsy findings available ompletion of cause of
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g Phy er this eral d	-	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe			119)100904
ath. r: Aft	atio	Natural 5 Pending 2 Accident investigat	(Month, Day, Yea	r) Injury		rk?]Yes 2 □No				
r Atte ter de irecto	ertification:	3 Suicide 6 Could not determine		At home, farm, st	treet, factory, office		28f. Location (a City or Tox		mber or Rui	ral Route Number,
urs aff	O									
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of my caminer: On the basis of examiner and manner stated.	mination and/or i	nvestigation, in my	opinion, death occur	rred at the time,	date and place	e, and due	stated. to the cause(s)
Fo the vithin Fo the complex	Me	29b. Signature and title of certifier	4		29c Licen	se number	,	29d. Date sig	ned (Month	, Day, Year)
		1 Olian	lins		1)	5000	>	MAY	7	2008
10 1		30. Name and address of person wh	no completed cause of death ((Item 23a) (Type	, Print)	16/0 1.2	- Mal	an	5	
U '		31. Date filed (Month, Day, Year)	32 Radietrar's S	6/10/ ignature #	N- Cla	se number 303	100	N/ F /	7	
Sta Registra	_	MAY 1	2 2009 Jeneur	B. 1	parker					

09-03555 Franklin Wooters Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ranklin Wooters	State State	e of Maryland / Departmer <i>Certificat</i>	nt of Health and Mental H e of Death	ygiene Reg. No.	2009 1527
Physician/	Registrar		0 0. 200	2. Date of Death	3. Time of Death
Medical Examiner	FRANKlin	I. Wooters		May 3, 2009	0620 1115
	4a. Facility Name (if not institution, g Johns Hopkins Bayview		4b. City, Town, or Location of Death Baltimore	1 4c. 0	County of Death
Funeral	Social Security Number 6.	Sex 7. Age (In yrs. last birthd		-	D/YYYY) 9. Birthplace (State or Foreign Country)
Director	213-68-9731 1	VM 2 F 49	Yrs. Months Days Hours Min	5-21-19	59 mb
à	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location		10d. Inside City Limits
- Fe war	n x		2		1 Ves 2 No
Maryland 28a-f show any d at once.	10e. Street and Number		10f. Zip Code		en of What Country?
with the Maryland us 23a or 28a-f sho be notified at once eral Director	1623 M	12. Was Decedent Ever in U.S. 1	t 21224		USA
r death with the Maryland , or items 23a or 28a-f sh must be notified at once Funeral Director	11. Marital Status 1 Never Married 2 Marri	Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 	o Rican, etc.)	4. Race - American Indian, Black, White, etc.
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		1 1 Voc 2 % No	1 Yes 2 No specify:	5	Specify: WKIte
215-0036 be filed within 72 hours after nital Hygiene. rked other than "natural", rent, the Medical Examiner Be Completed by	15. Decedent's Education (Specify		ecedent's Usual Occupation (Give kind of iring most of working life, DO NOT use re		ind of Business/Industry
36 in 72 h han "n hical E	Elementary/Secondary (0-12)	College (1-4 or 5+)	CAB DRIVER		Ransportation
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, La	st)	18.Mother's Nam	e (First, Middle, Maiden S	Surname)
215 be file ontal H- rked o	FRANKliN =	T. Wooters	Mailing Address (Street and Number or	RIA STRIC	kland
ID 21 should and Mer 77 is man matic ev	19a. Informant's Name/Relationship	(Type, Print)	Mailing Address (Street and Number or	St. The 14	y or Town, State, 219 Code)
alth	20a. Method of Disposition	ers - ncother 10.	Disposition (Name of cemetery,	Date 20c. L	ocation - City or Town, State
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Baltimore, permit. Pages I at Department of He Important: If ite	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic	censee	VIEW CIEMAKKU 5 22. Name and Address of Family B	radley - A	Show Funeral
	Tethank	mplications that caused the death. Do not	HOME, PA, 2134	or respiratory arrest, sho	ck, or heart Approximate Interval
Physician // Medical	failure. List only one cause on	mplications that caused the death. Bothot each line. a. Atherosclerotic c.			Between Onset and Death
taminer	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	ardiovascurar disc.		
	Sequentially list conditions,	b. Due to (or as a consequence of):			
- and a	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.			
ed nsit Examine	events resulting in death) Last	Due to (or as a consequence of):			
execut an and al - tra	X UNPENDED		ME, g891 5/15/09 T	Γ	
760, cate be physical he buri		23c. If yes, outcome of pregnancy			d. Date of delivery Month Day Year
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Division of Vital Recipital or Attending Physician: The Lours after death. Heral Director: After this certificate I filled in by the funeral director, page	Suicide 6 Could determ	not be		or Town, State)	
Fig. 6 Pi	29a Certifier	vsician: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the cause(s) and	nd manner as stated.
To the Hos within 24 h Completely	one) 2 ✓ Medical Exam	iner:On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre		Date signed (Month, Day, Year)
	29b. Signature and title of certifier	(/ 20)	O.C.M.E.	l	y 4, 2009
1	30, Name and address of person w	who completed cause of death (Item 23a)			
OCME	Melissa Brassell, MD	Assistant Medical Examiner	111 Penn Street, Baltimore, M	ID 21201	
Stat	POLITICAL PROPERTY.	2009 32. Figistrar's Signature	ball		

DHMH 17 Rev 1/2001

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State Registrar

DHMH 17 Rev 1/2001

barks

Malain Drive,

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2 2009

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Paul Wasserman 2009 6:32PM May 8, 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1 X M 2 □ F 053-18-8825 January 8, 1924 New Jersey Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4940 Sentinel Drive #203 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XXYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe Wasserman Sadie Ringelescu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krystyna Wasserman/ Wife 4940 Sentinel Drive #203, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cometer, crematory or other place)
Montgomery
Crematorium Inc. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) 2009 11, Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Veizous disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Noa 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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attending physician for use as the buria

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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

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Physician/Medical

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Completed page 2 should

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Certification: To

Medical

requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Department of Health a Important: if item 27 is any injury or other trauonce.

Physician

/Medical

Examiner

Directo

Funeral

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Pages 1 and 2 should be filed within 72 mer...

Pages 1 and 2 should be filed within 72 mer...

Iment of Health and Mental Hygiene.

The marked other than "natural", or items 23a or 28a-f show

The marked other than "natural".

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Nai

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

28f. Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical examiner?

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 No 1 🗆 Yes

1 ☐ Yes 2 No

28a. Date of Injury (Month, Day, Year)

1 Nopatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 28d. Describe how injury occurred

autopsy

1 ☐ Yes

27. Many er of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Heshmat, M.D. 10110 Molecular Drive, Rockville, Maryland 20855

State Registrar

32. Registrar's Signature

State

OCME 2006

DHMH 17 Rev 1/2001

Registrar

Ling Li, MD

31. Date filed (Month, Day Year NAY 1 2 2009

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signatur

			For State of Maryland / Dep	artment of Health and <i>rtificate of Death</i>		0000	10000	
			Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Death	eg. No. / 9	3. Time of Death	
П	Physici		Mary Elizabeth Armstrong		Month April	Day Year 26 2009		
wan de	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death		
and i	=Aum		2672 Red Toad Road	Rising S	un	Ceci1		
Ī	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		rs. 8. Date of Birth		nplace (State or Foreigr untry)	
н	Director		212-82-6393 1□M 2∏F 92 Yrs.	monard Bayo Trouto	Jan. 25	1917 Del	aware	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits	
	Maryl f sho	호	Marria di Caril	0			1∐Yes 2XNo	
	r 28a	Director	Maryland Cecil Rising 10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Cou	untry?	
	h with	a D	2672 Red Toad Road	21911		USA		
	ems deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Amer Black, White		
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ent, the Welfcal Everting rout be notified at	by Fu		1 □Yes 2 XNo Specify:	orto riioari, oter,	Specify:		
5-0036	hours tural"	g p	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	dent's Usual Occupation		16b. Kind of Business/I	White	
215	in 72 n "nal	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	e kind of work done during most of w DO NOT use retired)	vorking	Tob. Killa of Busilless/I	ndustry	
212	with giene r thau	E	Elementary/Secondary (0-12) College (1-4or 5+)	memaker		Own Home		
٦	be filed within 72 hours after death with the Marylan ttal Hyglene. Ed other than "natural", or Items 23a or 28a-f show event, I'm Medical Eventing I must be notified to	Be C	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, N	faiden Surname)		
<u>/lar</u>	should be f and Mental s marked o iumatic eve	5 E	George Brainard Ross	Clar	a Belle Di	ickerson		
Maryland	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or i	Rural Route Number,	, City or Town, State, Z	ip Code)	
	and lealth m 27 her tr	1 4	0	72 Red Toad Road	, , ,			
0	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)		20c. Location - City or T	Town, State	
Baltimore,	t. Par rtmen rtant: njury			•	/2009 I	Port Deposi	t, Marylan	
Ba	permit. Pages Department of Important: If i any Injury or one		21. Signature of Funeral Service Licensee	2. Name and Address of Facility T. Foard Funer	al Home, I	P.A.		
			23a. Part 1 Enter the disease, or complication, that caused the death. Do not en	11 S. Queen Stre			Approximate	
	Dhysisian	į t	shock, or heart failure. List only one a se on each line.	1.1 +	() ()		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	ardial Inta	VOTION			
	Examiner		C 0./0.00	Artern Disea	J.P.			
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0				
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	W. VI				
60,	icate be executed physician and the burial-transit		Due to (or as a consequence of):	lecter / trial				
98/60	ificate be executed physician and sthe burial-transit	edical	d. Clovated Civ	Teachell sirin	JOHN 1000			
ROX		J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	verv	
	death cert e attending id for use a	Physician/M	in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year	
л. Э	t the by the	hys	9 Unknown					
	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	pacco use contribute to		
Vital Records,	equire sen si ould b	E e	HTYIAI FIBYLIIATION		_ 1 □ Ye	s 2 ⊠ No 3 □ Pr	obably 4 🗆 Unknown	
ပ္တ	2 2 2	Completed			24a. Was ar autops	24b. Were au	topsy findings available completion of cause of	
<u>~</u>	Th pag	Col	-27		perform 1 ∐ Yes 2	ned? death? 2 ☑ No 1 ☐ Yes	2□No	
	Physician; The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		eath (Check only one			
0	ding Physician; h. After this certific funeral director,	<u>ا۔</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Mangier of Death 28a. Date of Injury 28b. Time of	nt 3 DOA Outer 4 Nursing	Home 5 X Reside	ence 6 Other (Spec	cify)	
0	th. : Afte	it or	1 Matura! 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No	2001 200112011	,,		
DIVISION	Atter	Hice	3 Suicide 6 Could not be 28e. Place of Injury - At home farm st	reet, factory, office	28f. Location (Str	reet and Number or Ru	ral Route Number,	
5	tal or s afte al Dir	Certification: To	4 ☐ Homicide determined building, etc. (Specify)		City or Town	i, State)		
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	edical	29a. Certifier (Check only Check only (Check only Amedical Examiner: On the basis of examination and/or in					
	the thin 2 the l	Med	one) and manner stated.	29c. License number		9d. Date signed (Monti		
	5.¥ 5 8		29b. Signature and title offertifiel	D 003392		4/12/20	i, Day, Tear)	
	-		30. Name and address of person who completed cause of death (Item 23a) (Type,)	1/2/10	J	
	0		Oliver S. Thresher Tr M.D.	10) Colonial	Way Siite	B Rumis S	un MD 219	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		-	10110	The state of the	
	Registr	ar	APR 28 2009 German B. Jan	Ked				

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

2009

4c. County of Death

Montgomery

14. Bace - American Indian.

Specify: Colored

Black, White, etc.

20770

6:15p M

Birthplace (State or Foreign Country)

10d. Inside City Limits

XXYes 2 □ No

20012

Year

Approximate Interval Between Onset and Death

Illinois

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Dav

2 1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify,

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

22100

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

17904 Georgia Avenue, Ste.304, Olney, MD Ata Motamedi, M.D.,

State Registrar

Registrar's Signatur

within 24 hours a To the Funeral I

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed To the Hospital or Attending Physician: Director: After this

Completed Be

25. Was case referred to medical examiner? Certification: To

Medical

1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Matural

29a. Certifier

2 Accident

3 ☐ Suicide 4 Homicide

5 Pending investigation

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

12 mmel

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2000 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** Date of Birth (Month, Day, Year) 2–13–1932 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 2 Age (In vrs. last birthday Min Days Hours 1 M 2 W F 579-48-1605 77 PANÁMA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location SUSSEX MILTON 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 25 HUNTERS MILL ROAD 19968 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 21X No 1 X Yes 2 □ No Specify: PANAMANIAN Specify: PANAMANIAN 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER NONE

18. Mother's Name (First, Middle, Maiden Surname)

20c. Location - City or Town, State

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

1 Yes

6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

600 North Wolfe St, Baltimore, MD, 21287

1 Yes

24a. Was an autopsy

5 Residence

28d. Describe how injury occurred

26. Place of Death (Check only on

Other: 4 \sum Nursing Home

2 No

28c. Injury at Work?

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Tes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 No

MILLSBORO, DELAWARE

Approximate interval Between

Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

EMITA RACINES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 HUNTERS MILL ROAD, MILTON, DELAWARE 19968

Date

MELSON FUNERAL SERVICES, LTD 32013 LONG NECK RD, MILLSBORO, DE. 19966

4-30-09

Physician /Medical Examiner For State Registrar

10a. State

Director

Funeral

by

Completed

Be

ဂ္

Examine

Physician/Medical

Completed by

Be

၉

Certification:

DELAWARE

11 Marital Status

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

4 Donation

21. Signa

23a, Part

IF FEMALE

1 X Burial 2 Crema

shock, or heart failure

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknow

in the past 12 months?

25. Was case referred to medical examiner?

1 🗌 Yes

Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(check only one)

2 NO

5 Pending investigation

Could not be

determined

disease or condition

resulting in death)

ENRIQUE CAMBRA

Enter the disease/o

19a. Informant's Name/Relationship (Type. Print) RAYMOND BENDER, SR./

SPOUSE

epsi

23c. If ves, outcome of pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Inpatient

28a. Date of injury (Month, Day Year)

and manner stated

9 Unknown

Hospital:

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of)

Live birth 2 - Fetal death

Pregnant at time of death

3 Removal from State

only one cause on each line.

20b. Place of Disposition (Name of

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest

3 Ectopic pregnancy

5 Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ŏ

items 23a

"natural", or iten edical Examiner n

er than "natur the Medical

7 is marked other traumatic event, th

27 item 2

Department of Important: If it any injury or o

must be notified

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

nent of Health and Mental Hygiene

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, the þ has page death. ector: A filled in by within 24 hours a To the Funeral Completely filled Hospital

			Plea						Ensure A	_		gible.	
		For State		Stat	e of M	aryland	•	artment of F rtificate of I	lealth and N Death	nental Hy	(1)	000	15285
		Registrar 1. Decedent's Nam	ne (First, Middle	e, Last)				incate or i	Death	2. Date of De		000	3. Time of Death
Physici: /Medic		Rush Bu	ickley,	Jr.						Month 4	25	2009	10:34 P ^M
Examin	er	4a. Facility Name (Atlanti		_)		4b. City, Town, or Berlin	r Location of Death			unty of Death Orcest	
Funeral		5. Social Security N	Number	6. Sex	7. Ag	ge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	rth		place (State or Foreign ntry)	
Director		577-50-6 Usual Residence o		TLAIM 2L	1 -	83	Yrs.			12/30	/1925		" VA
rryland show	_	10a. State	10b. County			10c. City,	Town or Lo	cation					10d. Inside City Limits
the Ma 28a-f	Director	MD 10e. Street and Nu		cester		Ber	lin	10f. Zip Code			10a. Citizen	of What Cou	1 ☐ Yes 2/CXNo ntrv?
be filed within 72 hours after death with the Maryland ntal Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene.	al Di	12 Fair		Court				21811			USA		,
tems (Funeral	11. Marital Status		Arme	ed Forces?		i. 13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14.	Race - Ameri Black, White,	
urs afte al", or i	þ	1 ☐ Never Man 3 ☐ Widowed		If Ye	Yes 2□ s, Give or Dates:	No	1	1 □Yes 2 🛛 No	Specify:		Spe	ecify: W	hite
72 hou	eted	(Spe	15. Deceden	t's Education of grade comple	eted)		(Give	dent's Usual Occup	durina most of work	ing	16b. Kind o	of Business/In	dustry
within jiene. r than	Completed	Elementary/Seco	ondary (0-12)	Colle	ge (1-4or ! 3	5+)		em Analys	*		FBI		
be filed tal Hyg d other	Be C	17. Father's Name	•						18. Mother's Name			name)	
hould by Meni	၉	Rush Bu					10h Mailin	an Address (Street	Ella and Number or Rui	Mae Wi		um Stata Zi	in Code)
nd 2 sl alth an 27 is r ir traur		Barbara							Court, E				o Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the March Examiner must be notified alonge.		20a. Method of Dis		3 Removal	from State	20b. Pla		sition (Name of natory or other place		Date		on - City or T	own, State
iit. Pag intment injury o			5 ☐ Other (S	pecify)		Cap		open Cre		/2009			DE
Depa Impo any i		21. Signature di Fi	M /	Muci	FL	rol e	/ I		am St., E	rbage l Berlin,	Funera MD 218	Home	
		23a. Frt1 Enter shoot, or hea	the disease, or art failure. List	complications to	hat caused on each li	d the death. ne.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a	140	ocan	dia	1 1	ntanc	tion	1		Onset and Death
Examiner					ie to (or as	a conseque	ence or):		196				
ed sit	iner	Sequentially list con a ry, Isacing to incause. Enter Under Cause (Disease or	erlying	D	ie to (or as	а сопарди	enes of):						
be executed ician and burial-transit	Examiner	that initiated event resulting in death)	S	c	e to (or as	a conseque	ence of):						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lical			d									
leath certificate b attending physic I for use as the bu	Physician/Medica	IF FEMALE:		23c. If ye	s, outcome	of pregnan	ncy				234	. Date of deliv	verv
death ne atter	siciar	23b. Was deceder in the past 12 1 ☐ Yes 2	2 months?	4 🗆		2 Fetal eat time of de		Ectopic pregnanc Other (specify) _	У		200.	Month	Day Year
w requires that the d been signed by the should be detached	Phys	9 ☐ Unknowr Part II. Other signi				out not resul	ting in the ur	nderlying cause give	en in Part I.	23e, Did	tobacco use o	contribute to	the cause of death?
quires 1 in signe	d by									1 🗆	Yes 2□N	lo 3□ Pro	obably 4 Onknown
e law re has bee e 2 shor	Completed									24a. Was		4b. Were aut	opsy findings available ompletion of cause of
Physician: The la r this certificate ha ral director, page 2											ormed?	death? 1 ☐ Yes	2 □ No
ysiclar is certif	o Be	25. Was case reference examiner?		Hospital:	1 npati	ent 2∏ E	R/Outpatien	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			Other (Spec	ifv)
ng Afte	D: T	27. Mann of Dea	th 5 🗆 Pendin		Date of Inju	ury :	28b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe			
Attendi death. ctor: A y the fu	ficati	2 ☐ Accident 3 ☐ Suicide	investiç 6 ☐ Could r	ation	Place of Ini	iury - At hon	ne. farm. stre		Yes 2 □No	28f. Location	Street and N	umber or Rur	ral Route Number,
tal or / rs after al Dire ed in b	Certification: To	4 Homicide	determ	ined	building, ef	c. (Specify))	eet, factory, office			wn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, it	edical	29a. Certifier (Check only one)		Examiner: On		of examinati			me, date and place opinion, death occur				
To the To the compl	Me	29b. Signature and	title of certifie	1	AL			29c. Licens	e number		29d. Date si	igned (Month	, Day, Year)
		O Name and add		210		do ath //tana	00a) /Tima	Doc	(733	3	4	281	09
BA6+1		P T M	LA FALA	10 6	29	East	rnn	Clarece	Do	Salis	by	M	D 21604
Sta Registr		31. Date filed (Mor			32. Registi	rar's Signati	ire	akel			7		
			APR 28	2003	Rose	the for	3. 1900	arvo-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2009 Alvin Dale BAKER USFO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington

9. Birthplace (State or Foreign Country) If Under 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 73 Feb. Director 2 1936 219-34-5166 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Washington Hagerstown 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 819 Maryland Avenue Funeral 21740 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 1956-59 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Furniture</u> Shipping Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin Everhart Baker မ Hilda Josephine Hose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorinda J. Roof - Sister Department of Health Important: If item 27 any injury or other to 11907 Comanche Dr. Smithsburg, Maryland 21783 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date) 20c. Location - City or Town, State Pages 1 ment of F 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 5/2/09 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 415 E. Wilson Blvd. Hagerstown, Md. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiosesman gne week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Physician: The law requires that the death certificate be executed burial-transit month and resulting in death) Last Due to (or as a consequence o Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Veal 5 Other (specify) the detached ģ signed I Part II. Other significant condition contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 XNo director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number D44996 Crause of death (Item 23a) (Type, Print) Loppans Rd Bransboro MD 21713 30. Name and address of person who comp SHB-10+1 31. Date filed (Month, Da egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Ma	ryland / L	•	ificate of L			Reg. No.	0000	1 = 0 0 =	
	Physicia	, n	1. Decedent's Name (First, Middle, Last)						2. Date of De	ath Day	ZUUJ Year	3. Time of Seath	
200	/Medic		Lester Roger Berr						03:00 A ^M				
de	Examin	er	4a. Facility Name (If not institution, give s 12301 Silver Rock				4b. City, Town, or Location of Death Lusby				alvert		
16	Funeral	A			(In yrs. last bir		If Under 1 Year If Under 24 Hrs.			th Your	9. Birthplace (State or Foreign Country)		
	Director		216–34–8328 ¹	M 2□F	71	Yrs.	Months Days	Hours Min.	Septembe	r 20,		hington, DC	
laryland	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ation					10d. Inside City Limits	
	faryla shov ed at	ō	Tour ording								1 □Yes 2X No		
	the N	Directo	10e. Street and Number		200.		10f. Zip Code			10g. Citi:	zen of What Cou	intry?	
	3a or		12301 Silver Rock Circle				20657			Unit	ted Stat	es	
	be filed within 72 hours after death with the Marylan tal Hygiene. In other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	2. Was Decedent E		13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (8 In, Mexican, Pue	Specify Yes or Norto Rican, etc.))-	14. Race - Amer Black, White		
	or it		1 Never Married 2 Married	1 XYes 2 N	X Yes 2 □ No. Yes. Give 1955 — 1		1 ☐ Yes 21 X No Specify:				te		
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	ges 1 and 2 should t of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type				Address (Street a						
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ē E	Pages nent of nt: If Its iry or o		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State			atory or other plac Cemetery	:e) \Drr:i 1	L 30, 2009	Solo	mons, Mar	yland	
alt	permit. Pag Department Important: I any Injury o	13	21. Sign Jure of Funeral Service License	e/ /) Solution		Name and Addres	ss of Facility	Rausch F	uner	al Home	P.A.	
ă	Dep lmp any		Thuchus Kave	Fartener	h		P.O. Box	600, L	usby, MC	206	57		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused e cause on each lin	the death. Do	not ente	r the mode of dyin	ig, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between	
	Physician	ě li	Immediate Cause (Final disease or condition	7.	Sladder concer						Onset and Death VEATS		
¥	/Medical Examiner		resulting in death)	Due to (or as a	a consequence								
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events								-2		
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ROX	ath ce tendii	Physician/M					B⊟Ectopic pregnancy G Other (specify)			23d. Date of delivery Month Day Year		very Day Year	
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7	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit								23e. Did	Did tobacco use contribute to the cause of death?			
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2	he la e has age 2	dmc							per	opsy formed?	death?	completion of cause of 2 kg	
Vital Hecords,		Be Co	25. Was case referred to medical					26. Place of De	1 Yes eath (Check only	2 No	1 10163	2000	
	nysici nis cer direc	.0	examiner? 1								cify)		
DIVISION OF	ding Ph	J: T	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?										
SIO	ter di eath. tor A the fu	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e Place of injury - At home farm street factory office 28f Location (Street and Number or Bural Boute N						ural Pauta Numbae				
Ž	or Atterion	rtifi	Suicide determined 28e. Place of injury - At home, farm, street, building, etc. (Specify)				et, factory, office 28f. Location (Stree City or Town, S				et and Number or Rural Route Number, State)		
_	spital ours at seral D		29a. Certifier 1' Certifying Phys	sician: To the best o	of my knowledg	ge, death	occurred at the ti	me, date and pla	ce, and due to th	e cause(s	s) and manner as	stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To th withir To th comp	Me											
			April 27th, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arati Patel 110 Hospital Road, Suite 212 Prince Fredericks M.						, 2009				
101	١, ٠, (ا		30. Name and address of person who co	ompleted cause of d	eath (Item 23a)	(Type, F	Print) City L	e 212	Prin	Ce	freder	ick MD	
χK	15+1		Avati Patel (1) 31. Date filed (Month, Day, Year)		ay's Signature	pad) -017	0.10	•	7	20	618	
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Registrar

APR 28 2009 Deneur

S. Sparked

			State of Maryland	•			lental Hyg	jiene					
An	Amended e1 masons Ind, 101D, 4/24/09 pila					rtificate of Death			Reg. No. 2009 5288				
	Physicia	an	1. Decedent's Name (First, Middle, Last) SARA_HUNDLEY			Month			of Death				
	/Medic	al	SARAH HINDLEY BARTLETT		4h City Trum and a	nation of Dooth	APRIL	21 200		0 A ^M			
	Examin	er	4a. Facility Name (If not institution, give street and number) WILLIAM HILL MANOR		4b. City, Town, or Loc EASTON	cation of Death			4c. County of Death TALBOT				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day		. Birthplace (State	or Foreign			
	Director		003-14-5817 1□ M XX F 84	Yrs.	Months Days F	Hours Min.	NOV. 24		Country) MD				
and	W		Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Loc	ation				10d. Inside (City Limits			
Maryla	f sho	ō								XX Yes 2 □ No			
the	rouit	rect	MD TALBOT EA	STON	10f. Zip Code		1	Og. Citizen of Wha	at Country?				
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deat		by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hispa Yes, specify Cuban, N	anic Origin? (Spe	ecify Yes or No-	14. Race -	American Indian, White, etc.				
s afte			1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XXVo		_	Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:	WHITE				
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and be file	lental Hygiene ked other thai ic event, Ire I		17. Father's Name (First, Middle, Last)		18	I. Mother's Name	(First, Middle, i	Maiden Surname)					
aryla should t	nd Mental Hygiene. marked other than matic event, It e M		ARTHUR F. HUNDLEY				JANE THOMAS						
Var 2 sh	and 2 s ealth ar m 27 is ner trau		19a. Informant's Name/Relationship (Type. Print)	•	Address (Street and		al Route Numbe	r, City or Town, St	ate, Zip Code)				
1 and			THOMAS D. LANE NEPHEW 20a. Method of Disposition 20b. Pla.		IALNUT LAN		N, MD 2	1601 20c. Location - Cit	ty or Town State				
Pages	unt of t: If it		I Li Buriai 2 Cremation 3 Li Removal from State		ition (Name of atory or other place)								
altıllo	artme ortan injur		4 □ Donation 5 □ Other (Specify) CHES. 21. Signature of Funeral Service Licensee		CREMATION Name and Address o		3-2009	STEVENS	VILLE, M	D			
permit.	Depa Impo any ir		JOHN R. MERCERON		LLOWS, HEI		& NEWN EASTON	AM FUNER	AL HOME,	P.A.			
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					-	Approxima Interval B	ate etween			
Ph	ysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Onset or condition										
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Jires 1	or death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	d b	Deafester Mellous	te Mellou				1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown					
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10			30. Name and address of person who completed cause of death (Item 2		n Easter	Mn	111001						
	Stat	e	31. Date filed (Month, Day, Year) 32. Fegistrar's Signatur	re 1	al d	1.100	1001						
	Registra		31. Date filed (Month. Day, Year) APR 2 4 2009 32. Fegistrar's Signatur	7. 190	W.Co.								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Year **Physician** 2009 Drawwock ranc /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HICOM ICO SAUSBUR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Days 1 □ M 2 😿 F Director Mary land Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show traumatic event, the Medical Examiner must be notified at 1 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number by Funeral OSEMONT 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗹 No Specify: 3 ₩Widowed 4 Divorced Black "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, Item Many injury or other traumatic event, Item Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ crence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD. 2/208 Frederick Baltimore Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cambridge, Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HENRY Fulle Ral Home, P. A.
510 Washington St. Cambridge. 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SCV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed A-1) Due to (or as a consequence of): Physician/Medical Renal IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the functional director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No After this certificate 2 No 2 🗆 No 1 □Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760. P.O. of Vital Records, **Division** iours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral L

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D57952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Das

State Registrar 31. Date filed (Mon



Division of Vital Records, P.O. Box 68760,

		Pleas 1 - State Registrar	e Type or Print in E State of Marylan	d / Depa		lealth and N	1ental Hygi	_	9 15290	
Physicia /Medica		1. Decedent's Name (First, Middle, Joseph H. Baum	Last)				2. Date of Death Month 4/25/		3. Time of Death	
Examine	er	4a. Facility Name (If not institution, g Anne Arundel Me	'		Annap			4c. County of E		
Funeral Director		415-42-4058	. Sex 7. Age (In yrs. 78	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 4/4/19	Year) 9.	Birthplace (State or Foreign Country)	
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th with the 23a or 28a ust be noti	al Director	10e. Street and Number 726 Jupiter Hi	lls CT.		10f. Zip Code	012	10	10g. Citizen of What Country? USA		
after des	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? ★★★★ 2 □ No Vi If Yes, Give Year or Dates:	etnam	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes AXNo	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, It which an	Completed	15. Decedent's (Specify only highest to Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+) 5+	(Give life.	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work d)	ing	16b. Kind of Business/Industry Military Law		
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h and l		19a. Informant's Name/Relationship	_		ing Address (Street			City or Town, Sta	te, Zip Code)	
t and F Health		Daniel Baum 20a. Method of Disposition	Son 20b. F		Tee Ct. Disting (Name of matory or other place)	Arnold, N		20c. Location - City	y or Town, State	
Pages nent of ant: If i		1 Burial 2 Cremation 3 Cremation 3	Hemoval from State 1 ~ 1		Mationy of other place National		2009	Arlingto	on, VA	
permit. Departi Importi any Inji		21. Signature of Europral Service Lic	censee		2. Name and Addres			neral Ho MD 2140		
*		23a. Part 1. Enter the isease, or co shock, or heart failure. List on	omplications that caused the deat ly one cause on each line.						Approximate Interval Between	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			dema.				Onset and Death 48 hours	
Examiner			Due to (or as a conseq	0	omyopa	thy ia	hopath	c .	>34ears	
red Isit	Jiner	If any leading to immediate Due to for as a consequence on:								
	ũ	Due to (or as a consequence of):								
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ath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								
w requires that the d been signed by the should be detached	<u>۾</u>	Part II. Other significant conditions Atrial Fibru	s contributing to death but not res	ulting in the u	underlying cause giv	en in Part I.	23e. Did tob		te to the cause of death?	
law req as beer 2 shou	Completed	Hypertension	1				24a. Was ar autops		re autopsy findings available r to completion of cause of	
: The icate h	8	Steep apnea	-				perform	ned? dear		
/sician s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	FR/Outnatie	ont 3 🗆 DOA Oth	26. Place of Deat		e) nce 6 ⊡Other ((Specify)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Injur Worl	y at	28d. Describe ho	· · · · · · · · · · · · · · · · · · ·	<u>эреспу)</u>	
al or Atters s after des la Director	Sertifica	3 ☐ Suicide 6 ☐ Could not determine		ome, farm, sti fy)	reet, factory, office		28f. Location (Sti City or Town	reet and Number o , State)	or Rural Route Number,	
e Hospit 124 hour e Funera letely filla	ledical ((Check only 2 Medical Ex	Physician: To the best of my knowaminer: On the basis of examination and manner stated.	ation and/or in	nvestigation, in my c	pinion, death occur	red at the time, da	ate and place, and	due to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	29	9d. Date signed (A	fonth, Day, Year)	
LXX	1	Barbara Los	inse Bean M	7	- D3°	1497	A	pril 25	2009	
10/20		30. Name and address of person when BARBARA LOU	ISE BEAN SU	ite So	0,2002,1	1edical	Parlewa	M. ANN	IAPOLIS	
Stat Registra		31. Date filed (Month, Day, Year) APR 2 8 20	and manner stated. in Se Blan More completed cause of death (Iter 33. Registrar's Signar 1009	ature de	w			J'		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:05 pM April 26 2009 William Bone Burleigh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Collington Retirement Center Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M 2 □ F Yrs. Director March 16, 1913 Missouri 215-44-8683 96 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 Tx No Director Maryland Prince George's Mitchellville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or 10450 Lottsford Road 20721 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any in ury or other traumatic event. The second once. 1 XYes 2 ☐ No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify: δ Specify: 3 Widowed 4 Divorced WWIT White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ U.S. Government Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hector Walker Burleigh Agnes Allison Bone ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Edward Burleigh - Son 2731 Vivians Way, Saint Leonard, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 E Cremation 3 ☐ Removal from State 04/30/2009 Ft. Lincoln Crematory Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Renal Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia cate has l , page 2 s autopsy performed certificate 2 🗆 No of Vital 1 ☐ Yes 2 K No 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural ours after death. Ieral Director: Af filled in by the fur 1 ☐ Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 24 hours a 29a. Certifler 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 MO D25079 April 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H. Yablonowitz, M.D., 7404 Executive Place, Suite 502, Lanham-Seabrook, Maryland 20706 32. Registrar's Signature Date filed /Month Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11, per Inf (891 5/14/09 TT)
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 4:55 2009 April 24, Anthony F. Benedetti p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 3629 Gleneagles Drive Apt 2A Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1 **x**M 2 □ F 64 Mar 27, 1945 DC Director 213-48-6414 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Wedical Examinan must be notified at 1 ☐ Yes 2 👿 No Director MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20906 3629 Gleneagles Drive Apt 2A Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1XYes 2 No If Yes, Give Year or Dates Vietnam 1 Never Married 2 Married Maryland 21215-0036 1∐Yes 2∏No Specify White Specify: ð - 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Plate Maker Printing s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Benedetti Mary Olga Florimbi ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Gary M. Benedetti /Nephew 18121 Hayloft Drive, Derwood, MD 20855 permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1🙀 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery Apr 28, 2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License Annedance 500 University Blvd W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** immediate Myccardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease vears Examiner Due to (or as a consequence of) law requires that the death certificate be executed vears Diabetes Mellitus II sician and burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical the, attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) o 9 I Unknown ۵. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Obesity Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has l autopsy The performed? 1 □ Yes 2 🗓 No certificate Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural the Funeral Director Af 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 27, 2009 D02338

Registrar

15+1

parke

3929 Ferrara Drive, Wheaton, MD 20906

32. Registrar's Signature

30. Name and address of person who completed wuse of death (Item 23a) (Type, Print)

Richard Delaney

APR

31. Date filed (Month, Day, Year,

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending pl

Completely filled in by the funeral director, page 2 should be detached for use as I To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After

State Registrar

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 448102 Der 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St NW #403 Washington, DC 20010 Irving 106 Peter Berkman 32. Registrar's Signature 31. Date filed (Month, Day, Year) **ORIGINAL**

DHMH 17 Rev 1/2001

Medical

The law requires that the death certificate be executed attending physicien and I for use as the burial-transil been signed by the s should be detached has certificate To the Hospital or Attending Physician: this Director: After that in by the funeral death.

Physician

/Medical

Examiner

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Funeral

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item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 7. Depertment of Health and Mental Hygiens important: if item 27 is marked other than "ns any injury or other traumatic event, the Media 2008.

Physician

/Medical

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filed within 72 hours after

altimore, Maryland 21215-0036

within 24 hours a To the Funeral Medical State Registrar

31. Date filed (Month, Day, Year)

APK Z & Loui

23a, Part1, Enter the dise se. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Examiner il any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 1 No ၉ 27. Manner of Death Certification: 1 Natural 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. American Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sydney Dy, M.D. 4041 Powder Mill Road, Beltsville, Maryland

32. Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Clifton E. Brown April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1100 Owens Road, #201 Prince George's Oxon Hill If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☑ M 2 □ F Director 245-54-1476 70 07/17/1938 Usual Residence of Decedent be filed within 72 hours atter death with the Maryland 10a, State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the wedical Evaminer must be notified at Director Prince George's Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20745 1100 Owens Road, #201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: <u>ک</u> 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) lal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Naomi Lloyd John Thomas Brown ပ Pages 1 and 2 should or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau Rufus E. Watson/Nephew 131 Rolph Drive, Forest Heights, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dopation 5 □ Other (Specify) Resurrection 04/28/2009 Clinton, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Light 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MUDEARDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Maliguayi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by autopsy performe 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Approximate Interval Between Onset and Death 10 hours 30 years 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) UNUN HI1/Rd #/02

10:13A

10d. Inside City Limits

USA

Black

1X Yes 2 ☐ No

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only

> Anderson MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 22 Shirley Virginia Brown County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6 evers Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 □ M 2 🖾 F Months Days 09/17/1945 226-58-8581 63 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No prince George's Upper Marlboro 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 201 Herrington Dr. 20774 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Program Analyst vears Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Allie Duffy Florence Roberts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher D. Brown/son 4928 Harford Ave., Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem. 4/30/2009 | Adelphi, MD 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee Mars 4217 9th St. NW Washington DC 20011 23a. Patri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheros et Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence off Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical **Examiner** Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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id other than "natural", or items 23a or 28a-f show event, the Medical Examiner is ust be rigitified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria detached signed by detact has

Physician/Medical

Completed by

Be

Certification: To

Medical

29b. Signature and title of certifier

The law requires that the death certificate be executed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division of Vital Records, P.O. Box 68760,

State Registrar

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Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?									
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown									
		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 700 1 Yes 2 700									
25. Was case referred to medical	26. Place of Death	26. Place of Death (Check only one)									
examine? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ome 5 ☐ Residence 6 ☐ Other (Specify)									
27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	8d. Describe how injury occurred									
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
20a Certifier 1 Certifying Pl	weights. To the best of my knowledge dooth assured at the time date and place a	and due to the source(a) and manner as stated									

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** John Tolson Cockey, Jr. APRIL 2009 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EASTON TALBOT THE MEMORIAL HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7-16-1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 70 Yrs. **Funeral** Months Days 1**X** M 2□ F Hours Min 219-34-4012 Claiborne, Md Director Usual Residence of Decedent 10a. State 10b. Counfy 10d. Inside City Limits 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Wedical Examinari, just be notified at Md Talbot Claiborne 1 ☐ Yes 2 XNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 23328 Cockey Road 21624 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2**X** No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) filed within If Hygiene. College (1-4or 5+) 12 years 4 commercial waterman Boatyard years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental F Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evone. John Tolson Cockey, Sr. ဥ Ethel Louise Kinnamon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley S. Cockey(wife) 23328 Cockey Rd. Claiborne, Md. 21624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Capitol Crematory 4-28-2009 Dover, De 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md. 21663 Approximate 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carinoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 | Yes 2 | No 3 | Probably 4 | Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has birector, page 2 s autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2Д1No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural 2 Accident

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: Juria after death.

Jeral Director: After this certific filled in by the funeral director, 24 hours a completely

within 2 TLS ca

5 Pending investiga	ation	Injury	Work? 1 ☐ Yes	2 □No	280. Describe now injury occurred				
6		nome, farm, street, factorify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
1 Certifying 2 Medical 8	Physician: To the best of my knexaminer: On the basis of examinand manner stated.	owledge, death occurr action and/or investigati	ed at the time, da on, in my opinior	ate and place n, death occu	e, and due to the	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)	_		
d title of certifier	- 1	P 2	9c. License num	nber		29d. Date signed (Month, Day, Year)			

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APR 27 2009

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4/24/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219 Kavita Mohan S. Washington St. Easton, Md. 21601

31. Date filed (Month, Day, Year)

3 Suicide 4 Homicide

(Check only one)

29a Certifier

29b. Signature a

32 Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** 0558 nase homas 2009 HPn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambrid If Under 1 Year If Under 24 Hrs. orchester 7. Age (In yrs. last birthday) 90 Dorchester General 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Year) 1 M 2 □ F Months Days Hours Min Pennsylvania 76-32-7262 Jan. 14, 1931 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It is invested to notified a once. 1 PYes 2 No Funeral Director MDDorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 In Yes 2 □ No / 9 48 If Yes, Give Year or Dates: / 9 6 8 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Black <u>ک</u> 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Policeman Navy-Yara 18. Mother's Name (First, Middle, Maiden Surhame 17. Father's Name (First, Middle, Last) Be Warfield ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) In. Silverspring 10309. Lariston MD,20903 Thomas Daniel Chase 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - Dity or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 102/09 Cemetery 5 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HENRY FUNERAL Home, P.A. 510 washington St. Cambri 23a. Part . Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MHASTATIC **Physician** Carcino disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ☐Yes 2☐No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ MOM 4 Unknown 1 🗆 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Da Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Division of Vital Records, P.O. Box 68760, has After this certificate within 24 hours are.

To the Funeral Director: After this c

or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

State

m.0 Widmailer Brica. 31. Date filed (Month, Day, Year)

APR 28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

Registrar

29a. Certifier

29b. Signature and title of certifier

ical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Pay, Year)

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Physicia Medical Examir		1. Decedent's Name	/Ciant Middelle							Reg. N	0.		
		Manue	,	_(Last) nio Quinte	ero Ced	illo			2. Date of Month April 7	Day	/ Year	3	3. Time of Death 0520 hrs
		4a. Facility Name (i	f not institution				4b. City, Town, o				4c. County of Montgome		-
Funeral Director		5. Social Security N		6. Sex 1. ☑M 2. F	7. Age (In yrs. 4		If Under 1 Yea Months Day	_		of Birth (MI 25/19		Coun	place (State or Foreign htry) nduras
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ath with the	Funeral D	11. Marital Status 1 X Never Marrie		12. Was Dec			s Decedent of Hi	ispanic Origin	n? (Specify Yes o Puerto Rican, etc.	r No-		America	an Indian, Black,
after de	by Fu	or Dates:						Honduras		Specify:			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 37 is marked other than "natural", or items 33s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed t	Elementary/Seco	ndary (0-12)	ify only highest grad College (1		during m	nt's Usual Occupa ost of working life			16b	. Kind of Busin		
215-0036 be filed within 7 ntal Hygiene. rked other than		9th 17. Father's Name (Last)		Labor		18.Mother's	Name (First, Mid	dle, Maide	Constr	uct.	1011
1215 d be file ental H arked o	æ	Daniel					2002-2016		a Cedil				
MD 21 d 2 should lth and Me n 27 is ma tumatic ev	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19ose J. Quintero/Nephew 11506 Higby St. Silver Spring, Md 20902										zip Code)	
re, N s I and f Healtl If item		20a. Method of Disp	oosition			Place of Dispos crematory or ot	sition (Name of ce her place)	emetery,	Date	200	c. Location - C	ity or To	own, State
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr	7	4 Donation 5 Other Specify: General Cemetery 04/29/09 Honduras 21 Signatur 1 Funeral Service Licensee 22 Name and Address of Facility John T. Rhines Funera									T Domo		
Bal permi Depar Impo		22. Name and Address of Facility John 17. Rhines Funeral 3005 12th St NE Washington DC 20017									1 nome		
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To the Hospital within 24 hours To the Koneral To the Figure Completely filled	Medical C	29a. Certifier 1	Certifying Ph Medical Exar	ysician: To the bes	of examination a	dge, death occu	rred at the time, o	date and place n, death occu	e, and due to the urred at the time,	cause(s) date and p	and manner a place, and due	s stated e to the	i. cause(s)
F 3 F 8	¥	29b. Signature and	title of certifie		la	in		se number			d. Date signed oril 8, 2009		h, Day,Year)
1	ļ	30. Name and addr		who completed caus			Street, Baltim	nore MD 1	21201				
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		1 - For State Registrar	State o	f Marylan	•	artment of rtificate o				giene leg. No. (2009	15	300
		1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	th Day	Year	3. Time o	f Death
Physic /Medi		Antonio Javier	Califa					1	April 25,			6:30) a ^M
Exami		4a. Facility Name (If not institution	n, give street and nui	mber)		4b. City, Town	or Location	of Death		4c. C	ounty of Deatl	h	
(9210 Watson Roa	ad			Silver	_				tgomery		
Funeral Director		5. Social Security Number 466-74-1415	6. Sex 1 XX M 2□ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day April 10,	, Year)	9. Birtl	hplace (State untry) Tex	
p ,		Usual Residence of Decedent		10- 04	Town and a	Town or Location					10d. Inside City Limits		
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shou ind N i mar	I.	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address (Stre	et and Numb	ber or Rura	l Route Numbe	r, City or T	Town, State, Z	(ip Code)	
nd 2 alth a 27 is		Griselda Pearl Cal	ifa /Wife		9210	Watson Ro	ad. Sil	ver Spi	ring. MD	20910			
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Page ent o	1	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		ial Garde:		May 1,	2009 M	lissio	n. TX		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	_	29a. Certifier 1 ☑ Certifvin	a Physician: To the	best of my know	wledge dest	n occurred at the	time date	and place of	and due to the	cause(s) c	and manner of	stated	
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e Hospital or Attending Physician: 24 hours after death. within 24 hours a

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

29a. Certifier 1 (Check only one) 2

Ling Li, MD

29b. Signature and title of certifier

31. Date filed (Month Dev, Your)

ca

and manner stated

32. Registrar's Signature Rusua

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 24, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Kenneth S. Chaney 2:20 A M 2009 25. April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8001 Trumps Hill Road Upper Marlboro Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 579 40 2730 79 <u> April 16, 1930 Maryland</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: from \$23a or 28a-f show important: if item \$7 is marked other than "natural", or items \$3a or 28a-f show any injury or other traumatic event, the "Accinal Examinar must be not fifted at any injury or other traumatic event, the "Accinal Examinar must be not fifted at any once." 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8001 Trumps Hill Road 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 ☑ Ves 2 □ No If Yes, Give Year or Dates: **Korean** 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify ð Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Builder 11th Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eldridge Chaney Bertha Jones ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Chaney (Wife) 8001 Trump Hill Road, Upper Marlboro, MD 20772 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) April 30.2 009 20a. Method of Disposition Wall 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service I 69 Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the shock, or heart Approximate Interval Between Onset and Death • mplications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Na I disease or anditi resulting in death) Physician vosvate 2001 /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed COVONAVY that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 0 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ∐Yes 2 🗆 No 2 🗀 🗡 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a, Certifier

1914

31. Date filed (Month,

29b. Signature and title of certif

Medical

MD

Registrar's Signature

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

hampaloux

32.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Opper Marilbors

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) р 24, 2009 April 7:35 SARAH ELIZABETH CONANT DRYDEN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Pocomoke City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan. 3, Worcester 804 Market Street Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🕱 F 88 1921 Virginia 220-52-8361 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Pocomoke City Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21851 LISA 804 Market Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: white 3 ₩ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hulda Clapper Leroy Conant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 E. Federal Street, Snow Hill, MD 21863 Raymond Dryden, III (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4/29/2009 ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pitts Crrek PresbyterianCenetery Pocomoke City, MD 22. Name and Address of Facility Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) a I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with in Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The Application of the Azi is marked other than "natural", or items 23a or improjury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be rany in Injury or other traumatic event, the Medical Examiner must be ranked.

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

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MD

attending physician and for use as the burial-transit certificate has been signed by rector, page 2 should be detacl

The law requires that the death certificate be executed

Box 68760,

P.O. I

Division or Vital Records,

or Attending Physician:

After this

s after death.

within 24 hours at To the Funeral C Hospital

Examiner Physician/Medical 2 Completed Be Medical Certification: To filled in by the

Hospital:

5 Pending investigation

6 Could not be determined

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 2

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

04-27-2009 John Whittaker, MD

BA 10

State Registrar 31. Date filed (Month, Day,

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

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			For State	State of Mar	•	artment of He rtificate of D			0000	15304		
			Registrar		Cei	Tillicate of D		Reg 2. Date of Death	. No. UUJ	3. Time of Death		
п	Physici	an	Decedent's Name (First, Middle, Last)					Month	Day Year	M		
	/Medic	cal	GORDON THOMAS DAU			4b. City, Town, or L.		April 26	4c. County of Death	6:00 p [™]		
1	Examir	er	4a. Facility Name (If not institution, give s			_						
			4417 Stockton Road 5. Social Security Number 6. Sex		In yrs. last birthday)	Pocomoke (City If Under 24 Hrs.	8. Date of Birth	Worcester 9. Birth			
н	Funeral Director			M 2□F	80 Yrs.		Hours Min.	8. Date of Birth (Month, Day, Y July 10,	1928 Mar	nplace (State or Foreign untry) vland		
			Usual Residence of Decedent							1		
	how	.	10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. tnside City Limits		
	a-f-	cto	MD Worcester		Pocomoke	City				1 Yes 2 XNo		
	th th	Director	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Co	untry?		
	23a	la	4417 Stockton Road			21851			USA			
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spec Mexican, Puerto F	offy Yes or No- Rican, etc.)	14. Race - Ame Black, White			
36	s afte or it	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specify: wh	ite		
21215-0036	72 hours after death with the Maryland naturel', or items 23a or 28a-1 ehow dical Exemples must be notified at	d b	3 Widowed 4 □ Divorced	Year or Dates:	162 Dogo	dent's Usuat Occupati		16	Sb. Kind of Business/			
15	n 72	lete	15. Decedent's Edu (Specify only highest grade	completed)	(Give	kind of work done du DO NOT use retired)	ring most of workin	ng is	D. KING OF BUSINESSA	industry		
12	within ene. then "	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		Laborer			Deliver	· 🗸		
	filed Hygi sther	BeC	17. Father's Name (First, Middle, Last)				8. Mother's Name	(First, Middle, Ma				
lan	id be ental ked ic ev	To B	Gordon T. Daughert	v			Nellie	Young				
Maryland	should be filed and Mental Hygi is marked other eumatic event, I	-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street an			City or Town, State, 2	(ip Code)		
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "naturel", or items 23a or 28a-f show emy injury or other treumstic event, the Medical Exemples count be notified at 905a.		Edward Daugherty (brother)	2223	Old Snow I	Hill Rd.,	Pocomok	ke City, M	D 21851		
ē,	f Hei		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	D	ate 20	c. Location - City or	Town, State		
Ë	Pages nent of I unt: If it		1 ABurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		e Cemetery	4/28/	2009 St	ockton, M	arvland		
Baltimore,	permit. Departmimporta eny inju		21. Signature of Funeral Service License									
m	Depa Impo eny i		Much 15	21. Signature of Funeral Service Licensee HOLLOWAY Funeral Home, Profession 107 Vine St., Pocomoke City, MI								
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Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of del Month	ivery Day Year		
	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death 51	Other (specify)				,		
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ot	Phys this ral dii	. To	1 Yes 2 No	1 ☐ Inpatient	2 ER/Outpatie	III 3 DOA	4 Nursing Hon	ne 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)		
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Š	or effer offer Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)			
_	To the Hospitel or Attending Physicien: The law within 24 hours effer death. To the Funerel Director: Affer this certificete has completely filled in by the funeral director, page 2	aic		sician: To the best of								
	1 24 Fulletely	Medical		ner: On the basis of e and manner state	xamination and/or in							
	withir To th	Me	29b. Signature and title of certifier			29c. License	number	296	d. Date signed (Mont	h, Day, Year)		
			I aul KHE	un M	0	024	872	4	1/27/0	9		
			30. Name and address of person who co	mojeted cause of dea	ath (Item 23a) (Type	, Pript)	. 1	′	1 /			
	BAY		30. Name and address of person who or PAUL FLEURY 31. Date filed (Month, Day, Year) APR 2 9 20	305 Tel	Wh ST	Pacomo	Ke CITO	MO	21851			
	Sta		31. Date filed (Month, Day, Year)	32. Pegistrar	's Signature	·						
	Regist	rar	APR 2 9 20	19 Drews	J. A.	arke						

DHMH 17 Rev 1/2001

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other that any injury or other traumatic event, 17 and 500ce.

Examiner Physician/Medical δ Completed Be (Certification: To in 24 hours
the Funeral Directory filled in by the

	d.									
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	23	ic. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Ecto					23d. Date of d Month	elivery Day	Year
art II. Other significant conditions	s cont	ributing to death but not resu	ilting in the underly	ing cau	se given in Part I.		23e. Did tobacco	use contribute ☑No 3☐		
							24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to	completion	
Was case referred to medical examiner?					26. Place of De	eath (C	heck only one)			
1 Yes 2 No	Ho	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[□ DOA	Other: 4 \(\sum \) Nursing	Home	5 Residence	6 ☐ Other (Sc	ecify)	
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury			i. Injury at Work? 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred			
3 Suicide 6 Could not determine		28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fa	ictory, o	office	28f.	Location (Street a. City or Town, State		Ru ra l Route I	Number,
Pa. Certifier (Check only one) 1 ☐ Certifying 2 ☐ Medical Ex	Physi amin	cian: To the best of my knower: On the basis of examination and manner stated.	wledge, death occi	urred at ation, in	the time, date and plan my opinion, death occ	ce, and	d due to the cause(s at the time, date an	s) and manner d place, and di	as stated. ue to the cau	se(s)
b. Signature and title of certifier				29c. l	icense number		29d. Da	ate signed (Mo	ith, Day, Yea	ar)
> Michael	a	1.1.		6	141667			5-1.	09	

Medical Compas Description MP.

WH-7 State

within 2

Medical

11110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clorneck

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Day **Physician** 8:03AM Tyvolia 2009 Dennis Douglas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 □ M 2 🕱 F 224-18-2493 Director 93 02-06-1916 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Directo Lanham 10f. Zip Code Md. Prince Georges 10g. Citizen of What Country? 10e. Street and Number 4401 Havelock Road Funeral 20706 USA 1 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own home 12 42 should be filed with and Mental Hygier 7 is marked other tt Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin 0 Dennis Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Bernice Austin/Daughter 4401 Havelock Rd., Lanham, Maryland 20706 of Disposition (Name of Date 200. Location - City or Town, State permit. Pages 1 and Department of Heali Important: If item 2 any injury or other 2000. injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Friendship UM Cem. 05-01-09 |Wattsville, Va. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bennie Smith funeral Home 1. Signature of Fune el Service Licensee 426 Dover St., Easton, Maryland 21601 4 mar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) s been signed by the a should be detached to 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥No 2-ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29c. License number completed cause of death (Item 23a) (Type, Print) 3RK SUU AMMARCE'S Kichons

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

2 9 2009

Examiner

Examiner

Physician/Medical

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Be Completed

Medical Certification: To

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

5 ☐ Pending investigation

6 ☐ Could not be determined

re and title of certifier

1 ☐ Yes 2 ☑ No

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

28a. Date of Injury (Month, Day, Year)

Due to (or as a conse

4 Pregnant at time of death 9 Unknown

Due to (or as a consequence of):

3 Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? [] [] 9

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

3. Time of Death

1**Y**]Yes 2 □ No

Approximate Interval Between Onset and Death

8:41

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

FREDERICK

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 No

29a. Certifier (Check only

29b. Signat

examiner?

27, Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number mo 00067210

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29d. Date signed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. 400

. Registrar's Signature 31. Date filed (Month, Day, Year) APR 28 2009

Registrar DHMH 17 Rev 1/2001

State

P.O. Box 68760.

Hospital or Attending Physician; The law requires that the death certificate be executed and attending physician funeral director, page 2 should After death. hours after deatl uneral Director;

Division of Vital Records.

within 24 hours a

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of War Registrar	aryiand / Depa <i>Cei</i>	rtificate of		vieritai riyy Re	eg. No.2 0 0 9	15308	
	Physicia	an	Decedent's Name (First, Middle, Last) Vonc. T.	omeoine Del			2. Date of Death Month	n Day Year	3. Time of Death	
No. of Street	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	orraine Del		r Location of Death	April	24, 2009 4c. County of Deat	3:50 P M	
-1			Glade Valley Nursing & Reh	ab. Ctr.	Walkersv			Frederic	ck	
	Funeral Director		217 - 28 - 5118 1□ M 2√ F	e (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 25	9. Birt Co 5, 1930 Ma	hplace (State or Foreign untry) aryland	
	land Dw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	Mary a-f sh	ctor	Maryland Frederick	Walkersv:	ille				1∏Yes 2∏No	
	ith the	Director	10e. Street and Number 56 West Frederick Street		10f. Zip Code	700	10	og. Citizen of What Co	untry?	
	ns 23a	Funeral	11 Marital Status 12. Was Decedent	Ever in U.S. 13.		793 Iispanic Origin? (Si	pecify Yes or No-	U.S.A.	rican Indian.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Examinant by notified at once.	<u>6</u>	Armed Forces? 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No.	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Origin? (Specify Yes or No- an, Puerto Rican, etc.) 14. Race Black, Specify:			
2-0	72 ho "natur	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of worl	king	16b. Kind of Business/	Industry	
121	within iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5		Schoo1					
pc	e filed at Hyg other	Be C	17. Father's Name (First, Middle, Last)		ool Bus D		ne (First, Middle, M			
Maryland	ould b I Ment rarked	2	Paul B. Jones				Ridenour			
Mar	d 2 sh th and 7 is π traum		19a. Informant's Name/Relationship (Type. Print) Robert L. DeLauter / Grand	I				City or Town, State, 2		
ē,	s 1 an of Heal item 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	koad, New	Date 2	Maryland 20c. Location - City or	ZI//4 Town, State	
<u>=</u>	Pages ment of hant of hant: If ite	П	A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Salem U.M			0/09 W	olfsville,	Maryland	
Baltimore,	21. Sign the of Entral Service four see ROBERT E. DAILEY & SON FUNERAL HOME ROBERT E. DAILEY & SON FUNERAL HOME 615 EAST MAIN STREET, THURMONT, MD									
		est,	Approximate Interval Between Onset and Death							
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	mention					MENTHS	
-	Examiner		Fa	a consequence of):	thrice				DAYS	
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. E. fat Url derying Cause (Disease or injury	a consequence of):						
	xecute and Il-trans	Examiner	that initiated events C.	a consequence of):						
68760,	tificate be executed g physician and as the burial-transit		d.							
9	ertificating physical as the	Medical	IF FEMALE:		(0) -1525					
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. or the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of dei Month	ivery Day Year	
<u>Ч</u>	hat the de ad by the a detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death be	at not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
Vital Records,	luires tha	d by	Dichetes.				1 □ Ye	s 2 No 3 Pr	obably 4 Unknown	
000	aw require as been si 2 should b	plete					24a. Was ar	24b. Were au	itopsy findings available	
ž	r: The law icate has b r, page 2 st	Som					autops perform 1 🗆 Yes 2	ned? death?	completion of cause of 2 🏻 No	
Vita Vita	Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?		oth	er.	th (Check only one			
ō	y Phys er this eral dii	٦: <u>۱</u>	27. Manner of Death 28a. Date of Inju	ry 28b. Time of	28c. Injur	y at	ome 5 ☐ Reside 28d. Describe ho	nce 6 ☐ Other (Spe w injury occurred	cify)	
ion	ttending F death. stor: After the funera	atio	1 Natural 5 Pending (Month, Da 2 Accident investigation	y, Year) Injury	M 1 🗆	k? Yes 2□No				
Division of	al or Atte s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dire completely filted in the	Medical (29a. Certifier (Check only one) Certifying Physician: To the best one and manner start.	of my knowledge, deat f examination and/or in	h occurred at the ti vestigation, in my o	me, date and place ppinion, death occu	e, and due to the carred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)	
	To the within to the To the Comple	Mec	29b. Signature and little of certifier	ned.	29c. Licens	e number	25	9d. Date signed (Mont	h, Day, Year)	
			17 -5		000	62223		4/27/0	9	
	5		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print)	REOBL	ICK MI	9d. Date signed (Mont. 4/27/0 0 21702	_	
	Stat Registra			ar's Signature	Rad					

DHMH 17 Rev 1/2001

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

/Medical

_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce
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3	Sta Registi	

Director 2608 OUIET WATER COVE Funeral 1 Never Married 2 Married ≥ 3X Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, if a liberity once. Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be HENRY HEATH ဂ္ 19a. Informant's Name/Relationship (Type. Print) LAWRENCE DUNNINGTON, SR./SON 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2**X** No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 LEFT HEMIPARESIS DUE TO STROKE Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No ۵ 27. Manner of Death Certification: 1 X Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI) D0054903 APRIL 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK J. KARKOWSKI, M.D., 139 OLD SOLOMONS ISLAND ROAD, ANNAPOLIS, MD 21401 Registrar's Signati

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Mi		rtificate of I	Death	Reg. I	No.2009	15310	
	Physicia	an	1. Decedent's Name (First, Middle,		oodman DOR	FMAN		Date of Death Month pril 27,	Day Year	3. Time of Death 8:59 A M	
of the same	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	0.33 A	
	LXaiiiii	C,	15101 Interlact				Spring		Montgome		
	Funeral Director		5. Social Security Number 214-42-6777 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2 1 F	e (In yrs. last birthday 95 Yrs.	If Under 1 Year Months Days	Hours Min. J	Date of Birth (Month, Day, Yea	914 Roman		
	yland iow		10a. State 10b. County		10c. City, Town or L				1	0d. Inside City Limits	
	e Mar la-f sh tiffed	ctor	Maryland Monto	gomery	Silver	Spring				1 □ Yes 2 No	
	ath with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 15101 Interlact				20906	Ū	10g. Citizen of What Country? United States		
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fune	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ XNo	ispanic Origin? (Specif an, Mexican, Puerto Ric Specify:		Black, White,	etc. i te	
15-0	n 72 h "natu edical	letec	15. Decedent (Specify only highes	t grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of working d)	16b	. Kind of Business/Ind	iustry	
12	withir iene.	omo	Elementary/Secondary (0-12)	College (1-4or s	i+)	nemaker	7		Own H o me		
nd	18. Mot						18. Mother's Name (F		den Surname)		
<u>y</u> a	ould by Meni	Samuel Reinis Lea 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or							fy or Town State Zin	Code)	
, Mai	and 2 shealth and 2 27 is n		Florence Band, I		e Drive, Be						
Baltimore, Maryland 21215-0036	Pages 1 and of He int: If Item inty or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		oe) Date	1	: Location - City or To Diney, MD	wn, State			
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service	icensee	ss of Facility Hebrew Fu			20012			
	Physician /Medical Examiner		23a. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):								
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
P.O. Box 6	Physician: The law requires that the death certificate has been signed by the attending I rail director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12/months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliver	ery Day Year	
rds, P.	e law requires that in as been signed by	by	Part II. Other significant condition	ons contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to t	he cause of death?	
Division or Vital Records,	The law rec	Completed						24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of 2 □ No	
/ita	ysician: The iis certificate hadirector, page	Be C	25. Was case referred to medical examiner?			Tou.	26. Place of Death				
or \	Physi this cral dire	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inj	ent 2 ☐ ER/Outpatie	BIIL 3 DOA		5 🗷 Residenc	e 6 □Other (Special	(y)	
on	ath. or: After ne funer	tion	1 Natural 5 Pendin 2 Accident investig	g (Month, Da	y Year) Injury	Wo	rk? Yes 2□No				
Divisi	or Atterder der Directo	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28e. Place of in building, e	jury - At home, farm, s tc. <i>(Specity)</i>	street, factory, office	28	f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,	
10	the Hospital hin 24 hours a the Funeral npletely filled	Medical C	29a. Certifier 1	g Physician: To the best Examiner: On the basis of and manner s	of examination and/or	ath occurred at the t investigation, in my	ime, date and place, an opinion, death occurred	d due to the caus d at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifie	1	. (29c. Licens			Date signed (Month,		
			/ soxan	Avun	- 'h		8381	A	pril 27, 2	.UU3	
			30. Name and address of berson Benjamin Avruni	n, M.D., 18	111 Prince	Philip D	rive, Suite	e 209, 0	lney, MD	20832	
	Sta Regist		31. Date filed (Month Day, Year)	2009 32 Aegist	rar's Signature	haves					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cynthia Lynn Davis State of Maryland / Department of Health and Mental Hygiene 1531 2009 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 22, 2009 1115 hrs Medical Examiner CYNTHIA LYNN DAVIS 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Gaithersburg 101 Odenhal Ave #610 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Months Days Hours 296-56-8706 Director Country) OHIO 53 May 14,195 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Gaithersburg 1 X Yes 2 No MD Montgomery 28a-f shov 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 28a-ust be notified at U.S.A. 101 Odenhal Ave., 20877 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married 2 X No Yes 0r Specify: White Divorced If Yes, Give Year . Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. It ant: I fitem 27 is marked other than "matural", or or other traumatte event, the Medical Examine: Yes 2 X No specify: Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Disabled None 2 yrs 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara A. Lane Edwin Lee Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 918-B Dillon Way, Lebanon, OH 45036 Edwin L. Davis (Father) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State 4/25/09 Hanover, MD artment c Ardent Crematory Donation 5 Other Specify. SNOWDEN FUNERAL HOME, 22. Name and Address of Facility 21. Sign Fure of Funeral Service Licen-246 N. Washington St, Rockville, MD 20850 Approximate Interval ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ase, or complications that caused the death. Do 23a, Part I. Enter the dise Physician Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine ause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Day Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 ✔ No 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available been 24a. Was an prior to completion of cause of autopsy has performed? death? 2 No certificate ✓ Yes 2 1 1 Yes 26.Place of Death (Check only one) Hospital or Attending Physicians 25. Was case referred to medical Division of Vital Be examiner? Hospital: Other4 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes No 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification 1 V Natural Yes 2 neral Director: within 24 hours after death To the Funeral Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 23, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Date 32. Resistrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Bulleting.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** D'Angelo Suzanne /Medical 4b. City, Town, or Location of Death
La Plata 4a. Facility Name (If not institution, give street and number) Examiner CENTER harle MEDICAL ULSTA If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days 1 □ M 2 🖵 F 3, 1946 Director 099 36 5343 62 Aug Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be rotified at 1 ☐Yes 2 ☐No Directo Maryland| St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28679 Patch of Woods Lane 20659 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Completed by Specify. White 3 ☐ Widowed 4XXDivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas D. Hughes Margaretta Durkin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nichole D'Angelo (Daughter) 28679 Patch of Woods, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Buria! 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory April 30, 2009 Clinton, Maryland 22. Name and Address of Facility Lee Funeral HOme, Inc 6633 01d 21. Signature of Funeral Frica Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final VERWHEL **Physician** D415 disease or condition resulting in death) Due to (or as a consequence of): osuso Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 □ Yes 2 **X**No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an rmear 2 **XN**o 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, signed by the a certificate has been s rector, page 2 should funeral director, filled in by the 24 hours after deat Funeral Director:

the

with

72 hours after

Pages 1 and 2 should be filed within innent of Health and Mental Hygiene. Int: If item 27 is marked other than "

Baltimore, Maryland 21215-0036

D'Ange

42ann

within 2

30. Name and State

Medical

120 31. Date filed (Month, Day, Year APR 28 2009

address/of pe

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

6 Could not be determined

Registrar's Signature 32

son who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

icense number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date şigned (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MAURICE M. ESKINAZI APRIL 25 2009 2330 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 8. Date of Birth (Month, Day, Year)
NOV. 30, 1917 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. TURKEY 91 NOV. Director 097-42-6448 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 28a-f shov 1 ☐ Yes 2 X No Funeral Director **MARYLAND** QUEEN ANNE'S CHESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1501 CALVERT ROAD 21619 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) 10 College (1-4or 5+) LEATHER CUTTER SHOES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental ဂ YAKO ESKINAZI ORO NEHAMA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAK ESKINAZI/SON 1501 CALVERT ROAD, CHESTER, MARYLAND 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State If it APRIL 28 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2009 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION STEVENSVILLE, MARYLAND 21. Signature of Funeral Sep 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease or complications the shock, or heart failure. List only one cause Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DODA Medical Certification: To 1 Yes 2 Na 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident hours after death the 1 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Dento 31. Date filed (Month, Day, 32. Registrar's Signature Year, State

Registrar

Saltimore, Maryland 21215-0036

Box 68760,

P.O. |

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 24°, 2009^{ear} April 1 8:40A. **Physician** James A. English /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Silver Spring Renaissance Gardens at Riderwood Village If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth (Month Day Year) OCt. 5,1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours Pennsylvania 207-16-3588 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nitury or other traumatic event, the Medical Expirity in mall by redifficial at once. 1 ☐ Yes 2 X No Maryland Prince George's Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 United States 3158 Gracefield Road, #216 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married White 1 □Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify <u>Ş</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) I.B.M. Computer Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Townsley Geery Frederick A. English 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3158 Gracefield Road, #216 Silver Spring, Maryland 20904 Roberta English -Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, Maryland Veterans Cemetery 5/1/2009 4 ☐ Donation 5 ☐ Other (Specify) Service Livenses nonaldanV.drBorgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Stroke Right Temporoperietal Infarct **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Alzheimer's Disease Dibility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Bilateral Pneumonia attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last P.O. Box 68760, Congestive Heart Failure Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗀 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy Month Year Day in the past 12 months? Pregnant at time of death 5 Other (specify) the TYPS 2 NO 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sh autopsy performed? Yes 2 XNo 2**X** No certificate 1 🗆 Yes 1 □ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medica Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Note: The place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Note: The place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 ddress of person who completed cause of death (Item 23a) (Type, Print) Anna Sisic, CRNP 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 24, 2009 **Physician** 10:26 A M Η. Ervin Sheila /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton. Southern Maryland Hospital 8. Date of Birth May 27, Day 944 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🛱 F North Carolina 64 241-70-7886 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hatural", or items 23a or 28a-f show any Injury or other traumatic event, fro Medical Examinat must be notified at angue. 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 ☐ Yes 2KKNo Temple Hills Director Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 USA 3723 Dunlap Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates: 1 ☐ Yes 2/11 No Specify Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) P.G. County Schools School Teacher 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Annie Juliette Avery Hicks မ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3723 Dunlap Street Temple Hills, Maryland John L. Ervin / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 1, 2009 Suitland, Maryland Ceder Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Fund I Service Licer 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on ea xi line Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours af

To the Funeral Di

completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certi

State Registrar

31. Date filed (Month, Day, Year)

APR 2 9 2009

Joseph Robinson

MD 106 Irving Street N.W. # 3600 Washington, D.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year April 26, 11:59P M Paul Colton Flester 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 3476 Chiswick Court 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 1, 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) Months Days Hours Min. 1 XM 2 ☐ F 1924 Washington, D.C 579-09-3575 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Silver Spring Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20906 3476 Chiswick Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1 XYes 2 ☐ No Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1943–45 1 Never Married 2 X Married 1 ☐Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Veterans Administration 12 Contract Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Augusta Burch Eugene Guy Flester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla D. Flester/wife 3476 Chiswick Ct. Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 04/29/09 Odenton, MD 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral \$ Goling "Homess Cremation Service P.O. Box 784 eve MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Failure month disease or condition resulting in death) Due to (or as a consequence of): 5 months Hyper Chloremic Renal Acidosis Sequentially list conditions Day to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Metastatic Prostate Cancer 10 years Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autonsy performed? 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at once.

altimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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MD

Examine burial-tran and attending physician for use as the buria Physician/Medical ed by the a signed I 2 cate has been signal page 2 should b Completed certificate director, Be Certification: To this funeral After t n 24 hours after death.

The Funeral Director: After the further than 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 10

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a, Certifier

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier Mour 2.01

D47682

29d. Date signed (Month, Day, Year) April 27, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2901 Olney Sandy Spring Rd. Olney, MD 20832 Bennett T. Morrison, M.D.

State Registrar

completely

within 2 the

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Medical

31. Date filed (Month

and manner stated.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

	•	for State Registrar		y	Certificate of	Death		Reg. No.	009	15311	
		1. Decedent's Name (First, Mid	dle, Last)				2. Date of De		Year	3. Time of Death	
Physicia /Medic		Darlene Fra	ances Frye						009	11:25 P.M	
Examin		4a. Facility Name (If not instituti	ion, give street and number)		4b. City, Town, o	r Location of Death		4c. (County of Death		
			erry Glen Lane		Glenn D		1		nce Geor		
Funeral		5. Social Security Number	6. Sex 7. Age 1	(In yrs. last bir	Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Cour	place (State or Foreign ntry) ryland	
Director	1	577-62-6975 Usual Residence of Decedent					Aug.	14, 1	740 Ma.	Lyland	
wow #	. [10a. State 10b. Count	ty	10c. City, Town	n or Location				1	0d. Inside City Limits	
a-f s	cto	Maryland Pri	nce George's	G1enn	Dale					1 □Yes 2X□No	
or 28	Director	10e. Street and Number			10f. Zip Code				en of What Cour	ntry?	
s 23a	sral	11411 Strawber			207		****		U. S. A.		
item	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? arried 1 ☐ Yes 2 ☒ No		13. Was Decedent of I If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	o Rican, etc.)	0- 1	4. Hace - Americ Black, White,		
ro,"l	by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	O	1 □Yes 2 🔀 No	Specify:			Specify: Bla	ıck	
atura	ted		ent's Education	16a.	Decedent's Usual Occup (Give kind of work done	pation	lein a	16b. Kin	d of Business/In	dustry	
ian "r	Completed	Elementary/Secondary (0-12)	nest grade completed) College (1-4or 5+	P) Res	life. DO NOT use retire search Speca	d)	•	1	S. Depa	artment	
ygien ver th t, the			2	Res	source Office	er			State		
ad oth	Be	17. Father's Name (First, Middle James D. Hardy				18. Mother's Nam	Dorsey		Surname)		
d Mer narke	မ		<u>-</u>	405	Maillian Addans (Chart				Tawa State Tie	- Codol	
than 7 Isr traur		19a. Informant's Name/Relation			o. Mailing Address (Street					0769	
Heal tem 2 other		Warren Frye/Hu 20a. Method of Disposition	ısbano		1411 Strawbe of Disposition (Name of orly, crematory or other pla		Date	_	cation - City or To		
ent of it: If i		1 ☐ Burial 2 ሺ Cremation 4 ☐ Donation 5 ☐ Other	3 Removal from State	1	ry, crematory or other pla Crematory		3/2009	Walde	orf, Mar	vland	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar is unit be natified at once.	1	21. Signature of Funeral Service		mance	22. Name and Addre			3			
a m m		1 pertition	inh		16000 Anna						
		23a. Part 1. Enter the disease,	or complications that caused to st only one cause on each line		not enter the mode of dyi	ng, such as cardiac	or respiratory	arrest,	ta dita y	Approximate Interval Between	
nysician		Immediate Cause (Final disease or condition	•		longio Carci	inoma				Onset and Death	
Medical		resulting in death)	a.	consequence							
xaminer		Sequentially list conditions.	b								
sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a	consequence	of):						
and I-tran	Examiner	that initiated events resulting in death) Last	c	consequence	of):						
sician				•	,						
ing physician and e as the burial-transit	Medical		d								
anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		۵□5.			2	3d. Date of deliv	ery	
ne atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown		n 3 ☐ Ectopic pregnand 5 ☐ Other <i>(specify)</i> _	су			Month	Day Year	
by the	Physician/	9 x k Jnknown					1				
igned be de	à l	Part II. Other significant condi	tions contributing to death but	t not resulting it	n the underlying cause giv	ven in Part I.	1			he cause of death?	
een s	te d						1	Yes 2	_No 3∐ Proi	bably 4XUnknown	
has b e 2 st	Completed							opsy	prior to co	opsy findings available empletion of cause of	
cate, pag							1 □ Yes	formed?	death? 1 ☐ Yes	2 □ No	
certif	Be	25. Was case referred to medic examiner?	Hospital:		Ott	26. Place of Dea					
r this eral di	5	1 Yes 2√XNo 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injur		utpatient 3 1 BOA	4 LI Nursing II	ome 5 Res 28d. Describe		Other (Special	(y)	
th. : Afte	ţ	Natural 5 ☐ Pend		(Year) I	Time of 28c. Inju 28c. Inju Wor	rḱ?]Yes 2 □ No	200.000.00				
r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Coul	28e. Place of Iniur	ry - At home, fa	arm, street, factory, office				d Number or Rura	al Route Number,	
s afte	Certification:	4 Hornicide	mined building, etc.	. (Зреспу)			City or 10	own, State)			
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use			ying Physician: To the best o al Examiner: On the basis of								
hin 24 the F nplete	Medical	one)	and manner stat								
Sor Sor	2	29b. Signature and title of certif		•	29c. Licens	se number 33299			e signed <i>(Month,</i> 23, 20		
NY.		4	m Julia		00						
13		30. Name and address of personal Cynthia M. Wi	·	, ,		V W . Was	hington	1. D	С.		
Sta	te	31. Date filed (Month. Day, Yea	ar) 32. Registra	r's Signature		, was		.,			
Registr		APR 2	7 2009 Seran	U B.	park						
					,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 5318 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4NABEL 1HR th **Physician** PRIAMIN 2560 200 20 /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOM HOSPITAT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours 217-36-7993 89 12/22/1919 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Exeminar nust be notified at 1 □Yes X No Director MD Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8100 Connecticut Avenue #618 United States "natural", or items 23a 20815 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2K No Specify þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Professor College 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Schullman Etta Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trai 38 Kingston Road, Kensington, CA Sura Wood/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4/30/09 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Brief the di_ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art fail are. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESARTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of): Box 68760, signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records. DIFFUSE DORMITTUS, ATRIAL MBRILLATON 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown should b Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physiclan: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
(Month, Day, Year) 1 Yes a No ဥ within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 27. Manner of Death 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 Pending investigation 1 Natural
2 Accident 1 ☐Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number APRIL 20, 2009 136252 pleted cause of death (Item 23a) (Type, Print) \$7 \$500 KONSINGTON MA 20895 KARY4, MD Registrar's Signature State Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Anya Marie Fitchett State of Maryland / Department of Health and Mental Hygiene														
	F	- For State Registrar	1.1-0	Cen		Reg. No.								
Physician Medical Examine	"	1. Decedent's Name (First, Midd	Marie	E	itche	++		2. Date of Death Month April 22, 20	3. Time of Death 1503 hrs					
/		4a. Facility Name (if not institution	on, give street and nur	nber)		b. City, Town, or L		 	4c. County of Death					
1	4	Rt. 309 approximately				Queen Anne		- 10 Date of Dist	Queen Anne					
Funeral Director		5. Social Security Number		7. Age (In yrs. Ia	2	If Under 1 Year Months Days	If Under 24Hr Hours Min		(MM/DD/YYYY) 9. I	eign Rhode				
	ŀ	U36-58-7661 Usual Residence of Decedent	1 M 2 V F	≪ &	Yrs.			3014.13	,1980	Island				
any	-	10a. State 10b. County						10d. Inside City Limits						
daryland 28a-f show	<u>ا</u> و	MD Ca	roline		Ride			1 Yes 2 No						
the Maryland a or 28a-f sh		10e. Street and Number	1 .	1		10f. Zip/Code	1//	10	g. Citizen of What C	ountry?				
sath with the litems 23a or		23990 J+ 11. Marital Status	015: NGE	edent Ever in U.S	NE	OX /	ent of Hispanic Origin? (Specify Yes or No-							
r death with the Maryland or items 23a or 28a-f sho		/	Armed Fo			es, specify Cuban,			White, etc					
s after de		3 Widowed 4 Div	orced If Yes, Give Year	2 F NO	1	Yes 2 No	specify:		Specify:	lack				
hours		15. Decedent's Education (Spe				's Usual Occupations of working life. I			16b. Kind of Busines	ss/Industry				
36 hin 72 e. than "		Elementary/Secondary (0-12)	College (1-	4 or 5+)	Pagi	stand	Nico		Hosp	1:401				
5-0036 led within 7 Hygiene. lother than	Completed	17. Father's Name (First, Middle	, Last)		Kegi	5 tered	8.Mother's Nam	ne (First, Middle, M	aiden Surname)	// u)				
1218 be fill be fill rrked vent, t	å	Rayno	nd Me	errit-	+		And	rian	ROSS					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygivers, and with the Maryland Important: If item 37 is marked other than "natural", or items 23a or 28a-f 5th injury or other traumatic event, the Medical Examiner must be notified at once	^ا≏	19a. Informant's Narfie/Relations	ship (Type, Print)	1 11	19b. Mailing			Rural Route Numl	per, City or Town, St	ate, Zip Code) 2/660				
and 2 tealth item 2 traun	-	20a. Method of Disposition	1-it chet			tion (Name of cem		Date Ri	20c. Location - City	or Town, State				
MOFE Pages I nent of F ant: If i		1 Burial 2 Cremation		III State	rematory or oth	·	or1/ 4	129/09	Danitan	Maryland				
Baltimore, permit. Pages I a Department of He Important: If ite Important: If ite injury or other to	4 Donation 5 Other Specify: Spring Grave Cemetery 7729/09 Denton, March 21. Signature of Funeral Service Licensee 22. Name and Address of Faility Hencey Fune Roll Home, P.A.													
De la initial		Janelle	C. He	nu	15	NRY FUN	hivator	1 St. Can	Abridge,	MD. 21613				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later that caused the beath of the mode of dying, such as cardiac or respiratory arrest, shock, wheart later than the mode of dying, such as cardiac or respiratory arrest, shock, wheart later than the mode of dying, such as cardiac or respiratory arrest, shock, wheart later than the mode of dying, such as cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, shock are cardiac or respiratory arrest, and the cardiac or respiratory arrest are cardiac or respiratory arrest are cardiac or respiratory arrest are cardiac or respiratory arrest ar												
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6876(certificate nding phy-	al	23b. Was decedent pregnant in t past 12 months?	ne 1 Live bi	rth	2 Fet	al death 3	Ectopic pregr	nancy	Month	Day Year				
Box e death c the attented for us	ysician/M	1 Yes 2 No 9 🗸 Un		ant at time of dea wn	ath 5 Oth	ner (Specify)								
that the d the by the detached		Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did tol	pacco use contribute	to the cause of death?				
5, P.O. inres that the signed by the detached by the betached										Probably 4 Unknown				
ords w requas been	autopsy prior to co									autopsy findings available to completion of cause of				
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Vital Rec ysician: The his certificate director, page	å	25. Was case referred to medica examiner?	Uponital:	patient 2	ER/Outpatient	- 10	of Death (Check Other: Nurs		Residence 6 🗸 O	than Saana				
n of Vi ling Physi After this funeral dir		1 ✓ Yes 2 No 27. Manner of Death	28a, Date o	of Injury	28b. Time of Ir	•	y at Work?		ow injury occurred	mer. Scene				
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ivisior I or Attend after death. Director:	E		stigation 28e. Place	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
Division o Hospital or Attending 24 hours after death, tety filled in by the fune	5 2	4 Homicide dete	3 miles south of	Rt. 404, Queen Anne, M										
To the Hospital within 24 hours To the Funeral completely filled	<u>g</u>		hysician: To the best miner:On the basis o											
To the within 7 To the comple	<u>₩</u>	29b. Signature and title of certifi-	and manner st	ated.		29c. License			29d. Date signed (
6		O.C.M.E.							April 23, 2009					
	-	30. Name and address of persor												
		Donna M. Vincenti, M		ledical Exam		Penn Street,	Baltimore, I	VID 21201						
Stat Registra	_	31. Date filed (Month, Day, Year)	37 2009 2	girtrar's Signatu	A. A	render								

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** April 23, 2009 7:59 P. M Cecelia Gannon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Date of Birth (Month, Day, Year) 11/24/1943 If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Days Months 1 □ M 2 🗓 F Maryland 65 Director 216-42-2472 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 Is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Calvert St. Leonard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20685 U.S.A. 5475 Long Beach Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) retail store sales associate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cumberland Rose Ube1 Charles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5475 Long Beach Dr., St. Leonard, MD Roland Gannon, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 04/27/2009 | Baltimore, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. of Funeral Service Licens 8325 Mt. Harmony Lane, Owings, MD 20736 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, etch line. 23a. Part1. Enter the disease, or complications that shock, or he art follure. List only one cause on Immediate Cause (Final **Physician** metastatic ung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an this certificate has 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

Jew

2001 Medical Pkwy., Annapolis, MD 21401

30. Name and address of person who compiled sause of death (Item 23a) (Type, Print)

2009

lexo

32. Registrar Signature

Stephen

31. Date filed (Month, Day, Year)

	1	For State		State o	of Mar	yland		rtment <i>tificate</i>				lental Hy	giene Reg. No		19	10	321		
	1. Decedent's Name (First, Middle, Last) 2								2. Date of De	ath		Vaar		of Death					
Physiciar /Medica													21	Day Year		4:18	Э М		
Examine		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital 4b. City, Town, or Location of Death Baltimore											4c. County of Death Baltimore C						
Funeral Director		5. Social Security N 131-26-		6. Sex 1 🔀 M 2 🗆 F		(In yrs. las	t birthday) _ Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 11 – 3	rth ay, Year - 193	33 1	9. Birthpl Count B roo	ace (Stat klyi klyi	te or Foreign		
yland now	Ī	Usual Residence o 10a. State Md	10b. County	o.t		10c. City, East	Town or Loc	ation							10	~ -	e City Limits		
be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, it Mcdail Evarines must be notified at Be Completed by Funeral Director	rector	Md Talbot East 10e. Street and Number						10f. Zip Code						10g. Citizen of What Co					
	ral D	503 Gai		1	21			'6-WN	USA cify Yes or No- 14. Race - American Indian,										
	2	11. Marital Status1 ☐ Never Mari3 ☐ Widowed	ver in U.S. Javy	13. V	Ispanic Oi an, Mexica Specify	ecify Yes or N Rican, etc.)	Black, White, etc. Specify: White												
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar, any injury or other traumatic event, It. Medical Expone. To Be Completed by		17. Father's Name (First, Middle, Last) Perino Thomas Gentile 18. Mother's Name (First Mandeline) Madeline										st, Middle, Maiden Surname) Falduti							
		19a. Informant's Name/Relationship (Type. Print) Julie Gentile (wife) 19b. Mailing Address (Street and Number or Rural Route Number of St., Easton,																	
		20a. Method of Dis	sposition Cremation	3 ☐ Removal from		20b. Pla	ce of Dispos	sition (Nam	ne of ther plac	ce)	1	Date 4-200	20c. l	Location -	City or To		•		
permit. Pa Departme Important any injury once.		4 ☐ Donation 21. Signature of F	5 ☐ Other (Si uneral Service)			Car	22	Name an	d Addre	ss of Faci	lity								
005 8 9	1	23a. Part 1. Enter the disease, or complications that a field the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line.									Md.	Approximate Interval Between							
Physician		shock, or heart fallure. List only one cause on lach line. Immediate Cause (Final disease or condition CON DESTIVE HEART FALLURE												nd Death					
/Medical Examiner		resulting in death) Due to (or as a consequence of):												6 VEHRS					
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es that the death certifigened by the attending be detached for use as by Physician/Me	/sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown										23d. Date of delivery Month Day Yea							
	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use ✓ntribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown							
: The law requir cate has been s page 2 should		24a. Was an autopsy performed?																	
an: Ti tificate tor, pa	O	25. Was case referred to medical 26. Place of Death (Check only of											NO	1 L Yes	2 🗆 100				
nysici	To B	examiner? Hospital: Other:										ome 5□Re	Residence 6 Other (Specify)						
iding Ph th. : After th : funeral	tion:	27. Manner of Death 1 \(\sumset \) Natural 5 \(\superset \) Pending 2 \(\superset \) Accident investigation \(\superset \) Accident \(\superset \) Pending investigation \(\superset \) Accident \(\superset \) Accident \(\superset \) Attract (Month, Day, Year) \(\superset \) 28b. Time of Injury at Work? 1 \(\superset \) Yes 2 \(\superset \) No																	
l or Atter after dea Director	Certification:	ACTO II II									28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	Medical C												anner as and due 1	stated.	ıse(s)				
To the within To the comp	Me	29b. Signature and title of certifier						29c. License number AT 2438946						29d. Date signed (Month, Day, Year) APRIL 21, 2009					
0+VA			-11	who completed ca	use of de	eath (Item	23a) (Type,	Duint)							M-				
	·o	31. Date filed (Mo	onth, Day, Year)	ZANNEK 32.	/ Megistra	r's Signati	ure	NON	11	EMO	RIAL	17057	PITA	-	1 , 7	, ,			
Stat Registra		31. Date filed (Mo	APR 2	4 2009	Dem	u ,	ure	arked											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Greathouse Μ. Robert 00 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 120 If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 18, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number ^{Year)} 1922 Days Hours Min Months 1 G M 2 □ F Tenn Yrs 86 578 22 6546 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes 2 No Mechanicsville Maryland S.t Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20659 29783 Adams Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc 1 □Yes 2 □ No If Yes, GiveXX Year or Dates: 1 Never Married 2 Married 1 □Yes 2 XX Specify. Specify: White 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Librarian Information Mgt. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lily M. Mallone Leroy Robert Greathouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Robin Greathouse (daughter) 29783 Adams Road, Mechanicsville, MD 20659 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery May 2, 2009 | Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Fune to S Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ct). Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? V5102 3 Probably 4 Nknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 0 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident

Jeannit, Pages 1 a, Department of Heah, Important: If item 27 any injury or others. **Physician** /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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of 2 should be filed within 72 hours after death with the Maryla tha and Mental Hyglene. The strength and Mental Hyglene and "natural", or items 23a or 28a-1 show 72 is marked other than "natural", or items 23a or 28a-1 show traumatic event, he weter that the intifficient is traumatic event, he weter the second of the strength of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the se

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Saltimore, Maryland 21215-0

the Maryland

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical ð Completed Be Certification: To

B16 State 29b. Signature and title of certifie

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

Medical

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mellon

ourt Suite 102 Waldorf MD A Shylo Patel 31. Date filed (Month, Day, Year) APR 28 2009

Registrar

BA 2

To the Hospital within 24 hours a To the Funeral C

3 ☐ Suicide

29a. Certifier

Medical

State

Registrar

4 Homicide

04-Market

31. Date filed (Month, Day, Year) 32. Begistrar's Signature APR 23 2009

JARAI 30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

R. BARAYMD

rocomo

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

04-20-2009

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 State Registrar (Check only one)

NEW

29b. Signature and title of certifier

Σ

CATTINIM.O. 101 COLONIAI 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hudlow **Physician** Dennis 1:55 AM 26 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maniland mirersily 01 timare a If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**⊠**M 2□ F 220-56-2770 58 Director March 26 1951 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan pepartment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Morceal Examine" must be incritised and 1 Yes 2 No Director Md. Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 26820 Howard Chapel Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ If Yes Give Specify. Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Contractor 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lois Stanton Thomas Hudlow Charles ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Thomas Hudlow / Son 11899 Lynn Crest Road, Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/28/09 Alexandria, Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Ko Say P. O. Box 5038, Laytonsville 20882 Approximate Interval Between Onset and Death 23a. Part 1. Ent. * t., disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) WEEKOAEB EA MEDICUL /Medical (or as a consequence of) Due * Examiner elvic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed 10 Due to (or as a consequence of P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 Vita 1 ☐ Yes l or Attending Physician: this certifical Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∑Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Division of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural MOTORCYCLE CULLISION 4/25/09 20:10 1 ☐ Yes 2 ☑ No death. 2 Accident after death

Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Koule and Hospital 24 hours a reet 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fill Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 296. Signature and title of certifier 29c. License number 29d. Qate signed (Month, Day, Year)

KB

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Regist APR 2 8 2009

Jennifer Kmald

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

B. Jank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 15326 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 250 PM Apn 1 2009 Valesta L. Harris 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) baltimore Washington Medical Center 5. Social Security Number J. 6. Sex T. Age (In vis. In Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 1 ☐ M 2 ☐ F Months Days 28 D.C 219-30-3221 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits XIIYes 2 □ No <u>Marylan¢ Anne Arundel</u> <u>Glen Burnie</u> 10e. Street and Number 10g. Citizen of What Country? 326 Gloucester Drive 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 5 vrs Nurse Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Godfrey H. Lawson Aurelia Stepney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type. Print) Leatrice Johnson (Daughter) 17200 Clairfield La. Upper Marlboro, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1. Taurial 2 ☐ Cremation 3 ☐ Removal from State 4/28/09 Bestgate Mem. Park Annapolis, Md. 21401 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licensee , Beese MOOY8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Das Due to (or as a consequent of) Sequentially list conditions, if any, leading to immediate cause. Enter the desired Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of deeth 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 2 No 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 1 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No .

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

Maryland 2121 and 2 should be filed within

Baltimore, Pages 1

Box 68760.

P.0.

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be

After

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Important: If it
any injury or o

Funeral Director

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Completed

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attending physician and for use es the burial-transi signed by the a

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Examiner Physician/Medical 2 Completed Be 2 Certification:

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	Part	11.
5		_

IF FEMALE 23b. Was decedent pregnant in the past 12 months

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 □Yes 2 □No

Duite 305 Glen Burne

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 <- ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

DO014147

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305

31. Date filed (Month, Day, Year)

Hospital

28a. Date of Injury (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Voar **Physician** 8:30 pM 2009 Ruth Louise Hill April 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Hospital Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 2 😿 F District of Columbia Director 216-22-0047 July 15, 1922 86 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2 X No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ or Items 23a 299 Hurley Avenue 20850 U.S.A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify ۵ 3 X Widowed 4 ☐ Divorced Caucasian "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Herbert Muzzy Grace Alleman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant; If item 27 is Department of Health Important: If item 27 any injury or other tra Kathleen Hill - Daughter 13826 Bronco Place, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/27/2009 Fort Lincoln Crematory Brentwood, Maryland 21. Signature of Furrial price Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** arouro disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed OYONEN and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown á signed Ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ pe 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 **X** No 1 🗆 Yes Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this Certification: To ...spital or Attending Pt. in 24 hours after death. funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 200 30. Name and address of person who completed cause of death (Item 23a) SAYEO ELSH 49AD 010 Molecular Dr. Rockville, MD istrar's Signature State Registrar

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			1 - State Registrar			Cer	rtificate of	Death		Re	eg. No		10020
			1. Decedent's Name (First, Middle	e, Last)					2.	Date of Death Month	Day	Year	3. Time of Death
	Physic /Med		Horace Daniel	Hollifield						April 2	22, 20	09	1:10A. M
	Exam		4a. Facility Name (If not institutio	n, give street and number	-)		4b. City, Town,	or Location of	f Death		4c. Count	y of Death	
			Suburban Hospi	təl			Bethes					gomer	
	Funera	1	5. Social Security Number	6. Sex 7. A 1 X M 2 ☐ F	ge <i>(In yr</i> s. 85	last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Min. T .	Date of Birth (Month, Day, Une 14	1 ^Y 63 ^x 3 2	9. Birthp	lace (State or Foreign Carolina
	Directo	r	259-16-8055	Aw Zu		Yrs.			J	uner4,	1923	Souti	COLUIIIO
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	farylt r sho	5	Maryland Prince			tsville							1 □ Yes 2X No
	the N	ect	10e. Street and Number				10f. Zip Code			10	Og. Citizen of	What Cour	itry?
	with a s		11713 Chilcoate	Lane			20705				United		,
	ING 21213-UU36 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, it all logical Exactions in a contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13. V		Hispanic Orio	gin? (Specif			ice - Americ	
	fter of	Ē	1 □ Never Married 2 X Mar	Armed Forces	?] No	1	Was Decedent of f Yes, specify Cu		, Puerto Ric	an, etc.)	Bia	ack, White,	etc.
ò	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII		1 □Yes 2 No	Specify:			Speci	ify:	White
(2 ho	Completed by	15. Deceder	it's Education		16a. Deced	dent's Usual Occi	upation	of working		16b. Kind of E	Business/Inc	dustry
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•	nd le file	Be (17. Father's Name (First, Middle,					1		irst, Middle, N			
-	VIOLE DE Ment Ment arkec	卢	Thomas Jackson	Hollifield				Harri	et Lu	cretia	Cann	on	
	and and selections and and and and and and and and and and		19a. Informant's Name/Relations			1	ng Address (Stree						
1	and and n 27		Bertie Lucille	Hollifield ·									
	es 1 of H	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Pomoval from State			sition (Name of natory or other pl		Date		20c. Location	-	
	Pag ment ant: I	4	4 Donation 5 Dother (5		ີ Ga	te of I	Heaven C	Cemet¢r	y 4/2	7/2009	Silve	rSpri	ng,Mərylənd
1	BAITIMORE, INIATYIANG 21213-UU35 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any Injury or other traumatic event, It all located Executi	2	21. Signature of Funeral Service	Licensee			Name and Add	ress of Facility	ardt	Funera	1 Home	. PA	ylənd 20 7 05
	D 907 2 4 5	5	Marid V	15 orgiva	4	4	400 Powd	<u>ler Mîl</u>	1 Roa	d Belt	sville	, Mar	
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that cause only one cause on each	ed the deat line.	h. Do not ent	er the mode of d	ying, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			y fail	ure					4	Onset and Death
	/Medica	•	resulting in death)	Due to (or a	s a conseq	uence of):							
- 27	Examine		Convention, list conditions	rheum	etic .	ərthri	tis						
	p ±	Examiner	Sequentially list conditions, it are, resume to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	Steeto (or e	s a current	ue roe of):							
	ecute nd trans	a	Cause (Disease or injury that initiated events	c									
٤ ع	e exercian a		resulting in death) Last	Due to (or a	s a conseq	uence of):							
am	OX 68/6U, certificate be executed inding physician and use as the burial-transit	n/Medical		d									
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	D = -		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 🗆 Feta	death 3	Ectopic pregna	ncy				ate of deliv	ery Day Year
	e de	sic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown		death 5 L	Other (specify)						
4/22/09	DIVISION OT VITAI HECOTOS, P.O. Bot of or Attending Physician: The law requires that the death after death. Director: After this certificate has been signed by the atter of the funeral director, page 2 should be detached for its both the funeral director, page 2 should be detached for the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the	Physicia	Part II. Other significant conditi	ane contributing to death	but not ree	ulting in the u	ndarlyina causa c	iven in Part I		23e Did tob	nacco use co	ntribute to t	he cause of death?
23	dS, ires th signe d be d	ğ	Failure to Thri	7	but not les	alting in the u	nderlying cause g	given in i circi.		1 □ Y€			oably 4 Unknown
7	COFO * requir * been s should	ted								1010			
4-	fec e law has b	Completed by								24a. Was al autops	n 24b	. Were auto prior to co	psy findings available mpletion of cause of
Pid	The I	5								perform 1 □ Yes 2		death? 1 □ Yes	2 [X No
1.6	r VITAL F yslclan; The is certificate director, pag	Be	25. Was case referred to medica examiner?						of Death (0	Check only on	e)		
4.	OT V Physical this call direction		1 Yes 2 No	4		ER/Outpatier	IL 3 LI DUA			5 ☐ Reside			(y)
-	on c	Certification: To	27. Manner of Death 1	28a. Date of In (Month, D	ijury D <i>ay, Year)</i>	28b. Time of Injury	W	ork?		d. Describe ho	w injury occu	irred	
72	ISIO Attendi death. ctor: A y the fu	cati	2 ☐ Accident investi	gation				□Yes 2□1					
٠. ·	r Att	Į	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place of It building, e	njury - At he etc. <i>(Specii</i>	ome, farm, str fy)	eet, factory, office	9	281	Location (St City or Town	reet and Nun n, State)	nber or Run	al Route Number,
23.	ital curs af	S		U.									
Horace Holli Field	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical	(Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	of examina								
J.	the hin 2. the supplet	led	one)	and manner s	stated.		00-11	BOO 00:00-			Od Date -	nod /\$4 11-	Day Year
1%	5 wit	2	29b. Signature and title of certifie					6531 Z		2	9d. Date sign	2/09	Day, Teat)
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	6+1		30. Name and dress of person Sudarahan Siva	M D 9600	death (Iter	m 23a) (Type,	Print)	d Dath	oods	Moses -1 -	md 200	1 /	
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		tate	31. Date filed (Month, Day, Year, APR 2	8 2009 32. Hegis	trar's Signa	A. A	a del						
	Regis	ırar	MEN &	J. 2000	المساليمان	13. 19	Warne						

09-03264 Dale Hawkins

Ме

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 15329

		1- For State Registrar				Cei	rtificate of	Death					Reg. N	D			
Physicia	_	Decedent's Nam	e (First, Midd	le,Last)					_		2	2. Date of De		Yea		3. Time of Death	1
dical Exami		DALE	ANDRI	Ξ HA	AMKIN	IS						Month April 23,	2009	168	<u>'</u>	1215 hrs	
		4a. Facility Name (if not institutio	n, give stre	et and num	nber)	4	b. City, To	wn, or Lo	ocation of	Death		1	4c. County c			
		7721 Lucky	Lure Roa	d			1	Clinton Prince George's									
Funeral		5. Social Security N		6. Sex	7	. Age (In yrs. I	ast birthday)	If Under		If Under		8. Date of I	Birth (M	M/DD/YYYY	9. Birt	hplace (State or I	Foreign
Director		186-52-	1398	ХХм	2 F	44	Yrs	Months .	Days	Hours	Min.		64	,	PEI	NSYLVA	NIA
	ŀ	Usual Residence o	f Decedent										, , , , ,				
any	ŀ	10a. State	10b. County				, Town or Locati									10d. Inside City	
ž ,		MD	PRING	CE GE	EORGE	ES		CLI	NTO	N						XX Yes 2	No
rylan a-f sl	용	10e. Street and Nu	mber					10f. Zip C	code				10g. C	itizen of Wh	nat Cour	ntry?	
or 28	Director	7721 Lt		LURE	ROAL)			073	5			UN:	TED	STA	TES	
r death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status				dent Ever in U	S 13 W/s				n? (Sne	cify Yes or I				can Indian, Black	ζ,
ath w	Funeral	Never Marri	ed 2XXV	larried	Armed For	ces?		es, specify					_	White	e, etc.		
, or i		3 Widowed		orced If Ye		2 X X №	1	Yes 2X	ΥNo	specify:				Specify:	BLA	CK	
2 hours after "natural",	<u>a</u>	15. Decedent's E		or.D	ates:	e completed)	16a. Deceden	t's Usual O	ccupatio	n (Give ki	nd of wo	ork done		. Kind of Bu			
2 hou "nat	ted	Elementary/Sec			College (1-		POLIC	net of worki	ing life [OO NOT II	se retire	ed)		M.W.A	. A .	•	
5-0036 Hed within 72 Hygiene. d other than "	ompleted	12TH	., ()		YEAF			DISP	ATC	HER		.110					
5-0036 led within 7 Hygiene. other than	팃	17. Father's Name	(First, Middle								Name ((First, Middle	e, Maid	en Surname)		
B 21215-00; should be filed within and Mental Hygiene 7 is marked other th	Be C	MATTHI		ONES,	JR.				P	ATR	CIZ	A ANN	I H	AWKIN	S		
212 ould be Ment mark	ol	19a. informant's Na	ame/Relations	ship (Type,	Print)									City or Tow			
MD d 2 sho lth and n 27 is aumatic		RENEE M	. HAW	KINS/	/WIFE	E	7721	Luck	y L	ure	Roa	ad, C	lli	nton,	MD	20735	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		20a. Method of Dis	position			20b.	Place of Dispos	ition (Name	e of ceme	etery,	7/7 1	Date			,	Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1XX Burial 2	Crematio	n 3 F	Removal fro	m State MC	Keesbo	T t =	Car	m		702 ,	I.	скее	spo	rt, PA	ļ
Itimen ritmen y or o		4 Donation 5															
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27		TERRENC	E	TUHN	SON	#993	173	RREN	hi+	e Pi	JOHI	NSON Is La	FUI ne	NERAL	, SE te	RVICE, Plains	PA MD
Physician		23a. Part I. Enter t														Approximate I	Interval
/Medical		failure. List or	nly one cause	on each lir	ne.											Between Ons Death	
xaminer		Immediate Cause or condition result				consequence	nd of Head		-							+	
				b.	.5 (5) 45 6												
	ē	Sequentially list co if any, leading to in	mmediate		to (or as a	consequence	of):										
	Examiner	cause. Enter Und (Disease or injury	that initiated	С.	h- /		-f):										
ed 1sit	Exa	events resulting in		Due	to (or as a	consequence (OT):										
3760, ificate be executed g physician and s the burial - transit	<u></u>	LINDENDES	`	d	MENDED								-				
O, e be e sicial	edic	UNPENDED									_			23d Data -	f dollar-	<u></u>	
	Σ	IF FEMALE: 23b. Was deceden	t pregnant in t	la a		outcome of pre	gnancy 2 Fe	etal death	3	Ectopic	pregnar	ncy		23d. Date of Month		y Day Ye	ear
K 68 1 certi endin use as	cial	past 12 month		4		ant at time of d	oath	ther (Speci				,					
Box 687 he death certific the attending p	hysicia	1 Yes 2	No 9 Ur	iknown g	Unkno	wn											
O. at the 1 by the tacher	۵	Part II. Other sign	ificant condi	tions con	tributing to	death but not	resulting in the	underlying	cause gi	ven in Par	rt 1.					the cause of dea	
ords, P.O. In requires that the as been signed by to should be detached.	d by											1	Yes 2	2 ✓ No 3	Pro	bably 4 Unk	known
Records, The law require ficate has been si, page 2 should t	Completed											24a. W				utopsy findings a completion of cau	
COI law has t	ldu											pe	itopsy erforme	<u>d</u> ?	death?		
Re The ficate	Col								e Dia	of De-th '	Che-li	-	es 2	No 1	1 🗸 Y	es 2	No
ing Physician: The law After this certificate has Tuneral director, page 2 sl	Be	25. Was case refe examiner?	rred to medic	al Hospi	ital: , 🗀 .	anation! of	ED/Outration			of Death (Other		g Home 5	Por	sidence 6	V Othe	r: Scene	
Physi r this	_C	1 V Yes	2 No		1 11	npatient 2	ER/Outpatien			y at Work				injury occur		a. Scelle	
n of ding Ph	:uc	27. Manner of Dea		aline.	28a. Date FOUND:	Day,Year)	FOUND:	jury Z		es 2 🗸	- 19	Subject s			. 00		
Sior Attenc r death ector: by the	ati	2 Accident		nding estigation	Apr 23, 2	2009	1212 hrs	ot fact				20f Lacati	n /6*	et and Numb	ner or D	ural Route Numb	er City
Division of Vital ral or Attending Physician: rs after death. al Director: After this certiled in by the funeral director	Certification:	3 🗸 Suicide		uld not be ermined			home, farm, stre	et, iactory,	OHICE DL	unuing, etc		or Tow	n, State)			or, only
spita hours neral	Ç	4 Homicide				Single Fa								Road, Clir			
Division of Vital Records, P.O. Box 68 within 124 hours after death certificate at the transfer death. To the Huspital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier (Check only ona)	Certifying F	hysician:	To the besite of	t of my knowle	dge, death occu and/or investiga	irred at the	time, dat	te and pla death occ	ce, and	due to the o t the time. d	ause(s ate and) and manne I place, and	er as sta due to t	ted. ne cause(s)	
To th within To th	Medical			and	manner st	ated.	a		_	number						onth, Day, Year)	
	2	29b. Signature and	u title of certif	ier ,/	m 1	1 .		290						on Date sign April 24, 2		anan, Day, (Cai)	
		Coc	rol	1	ttll	Lau			O.C.N	vi.⊏.				τριπ 24, 2	.000		
_		30. Name and add						04	2-143		0400						
В		Carol Allan				Examiner	111 Penn	Street, E	saltimo	ore, MD	2120	1				_	
	tate		APR'2	8 200	9 32. Re	gistrar's Signa	d. A	No Want	*								
3/0/01/9	o a de Ta																

samuei Lee Ha		1- For State Registrar_	tate of Maryland		rtment of tificate of		d Men		Reg	J. No.	009	
Physic Medical Exam		Decedent's Name (First, Mid Samuel Lee Ha							Date of Death Month pril 22, 20		Year	3. Time of Death 0928 hrs
		4a. Facility Name (if not institut	ion, give street and number	er)	4	b. City, Town, or	Location of		PIII 22, 20		nty of Death	
A		Southern Maryland F				Clinton					e George	
Funeral Director		5. Social Security Number 237-70-4723	6. Sex 7. / 1X M 2 F	Age (In yrs. Ia:	st birthday) 54 Yrs.	Months Day	_	_	02/10	•	Foreign	hplace (State or n untry) NC
aus		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, 1	Town or Locati	on					$\overline{}$	10d. Inside City Limits
	ı	MD Princ	e George's	Clir	nton							1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Coun	try?
with the Maryland ns 23a or 28a-f sbo be notified at once.		12600 Applecro				20735					USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien are. T is marked other than "natural", or items 23a or 28a-f she amatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X	12. Was Decede Armed Force	s?		s Decedent of His es, specify Cubar					ace - Amerio /hite, etc.	can Indian, Black,
fter de I", or		3 Widowed 4 D	1 X Yes	2 No	1	Yes 2X No	specify:			Speci	fy: B1	.ack
nours a natura Xami	ed by	15. Decedent's Education (Sp				s Usual Occupat			done	16b. Kind of	Business/Ir	ndustry
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12 12	College (1-4 c	r 5+)				add rearres)		- 1	1.0	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Som	17. Father's Name (First, Middle	e, Last)		secret	Service		's Name (Fir	st, Middle, M			vernment
21215 21215 21 215 215 215 215 215 215 215 215 215 215	Be	Joe Hampton						glen (
D 27 should and Me	၉	19a. Informant's Name/Relation				Address (Stree						
- 0 E E E		Betty A. Hamp 20a. Method of Disposition	ton/wire	20b. Pi		Appleca tion (Name of cer		Drive,			4D 207	
Baltimore, MD 2121 permit. Pages I and 2 should be fi gesparment of thenth and Mennal important: If then 27 is marked nijury or other traumatic event,		1 X Burial 2 Crematic		State cr	ematory or oth	er place)					•	
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Balt permit. Departs Import		One D. D	Truldand		65	00 Aller	ntown	Rd.,	Camp S	Spring	s, MD	
Physician // Medical		23a. Part I. Enter the disease, of failure. List only one caus		d the death. I	Do not enter th	e mode of dying,	such as ca	ardiac or res	piratory arres	st, shock, or	heart	Approximate Interval Between Onset and
kaminer		Immediate Cause (Final diseas or condition resulting in death)	Atherosclerotion			ease						Death
		Sequentially list conditions,	b.	sequence or)								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	sequence of)	:							
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	sequence of)	•							
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi		- INDENDED	d		_							
50, te be e nysician burial	Wedical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outc	ome of progra	ancu					22d Date	e of delivery	
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ox (eath ce attend for use	sici		14 Pregnant 9 Unknown	at time of dea	th 5 Oth	er (Specify)						
O. B at the d by the ached	Physi	Part II. Other significant cond		ath but not res	sulting in the u	nderlying cause g	jiven in Pa	rt I.	23e. Did tob	acco use co	ntribute to t	he cause of death?
ires that the signed by	d by	Chronic alcohol abu	se						1 Yes	2 No	3 Proba	ably 4 🗹 Unknown
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n of Vital Recing Physician: The After this certificate funeral director, page	Be	25. Was case referred to medic examiner?	Hoppital:				Othor	Check only				
of Vi Physic er this rral dir	은	1 Yes 2 No 27. Manner of Death	,,,,,,,, .		R/Outpatient 28b. Time of In		Other	Nursing Ho	Describe ho	esidence (
Division of Vital Records, rial or Attending Physician: The law require and after death. In Director: After this certificate has been sided in by the funeral director, page 2 should be	Ë	1 V Natural 5 Per	28a. Date of Ir (Month, Day	Year)	LOD: THIS OF H		res 2		. Describe no	W IIIJUIY OCC	uneu	
VISIC or Atte ter dez birecto	fica		estigation 28e. Place of	Injury - At hor	ne, farm, stree	t, factory, office b	uilding, etc	c. 28f.			mber or Rur	al Route Number, City
Divis pital or At ours after d teral Direct	Certification:	4 Homicide dete	ermined (Specify)						or Town, Sta	ite)		
Division of Vital Records, P.O. Box 68760, To the Hoppital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deem. The the Winterl Directorn. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			Physician: To the best of aminer:On the basis of ex									
To t with To t	Medical	29b. Signature and title of certifi	and manner state			29c. Licens						th, Day, Year)
2		Kell the	5 M	P		O.C.I			- 1	April 23,		
	ŀ	30. Name and address of person										
Æ)		Russell Alexander MI				Penn Street,	Baltimo	re, MD 2	1201			
S Regis		31. Date filed (Month, Day, Year, APR 2 9 200)	32. Regist	ar's Signatur	acked							
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DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2:30 P M APRIL 21, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S MANOR CARE LARG0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 1933 JAPAN **Director** 577-74-3705 76 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r tems 23a or 28a-f show 1 Yes 2 No **Funeral Director** PRINCE GEORGE'S FORESTVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2571 OAK GLEN WAY USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced **JAPANESE** 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE'S AID VILLA ROSA 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) UNK Be h and Mental F Pages 1 and 2 should be TANAKA ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2570 OAK GLEN WAY FORESTVILLE, MD LINDA HALLMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 04-24-2009 | ALEXANDRIA, VA 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 21. Signature of Funeral Service Lidence DEREK E. SLOCUM 4308 SUITLAND ROAD SUITLAND, MD 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR Acadent **Physician** /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Diabetic Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) of Vital Records. P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? utestinal Bleeding 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛛 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04-23-2009 D 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 SOUTHERN AVE. SE WASHINGTON DC 20032 PISHDAD, MD BAHRAM State APR 2 9 2009 Registrar

DHMH 17 Rev 1/2001

		State of Maryland / Dep		nd Mental Hyg	iene	15332
		1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Death	eg. No.	3. Time of Death
Physicia	ın			Month	aa awgear	16:50 PM
/Medica		FERREZ RAHNAM HALL 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death	
		The Johns Hopkins Hospital	Baltimore City			
Funeral		5. Social Security Number 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday,	Months Days Hours	Min. (Month, Day,	Year) Cou	iplace (State or Foreign ntry)
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ne Ma 18a-f s tiffied	Director	MD PRINCE GEORGE'S SUITLAND			Dg. Citizen of What Cou	
with the		10e. Street and Number 3845 ST. BARNABAS RD #201	10f. Zip-Code 20746		USA	muy:
ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin	n? (Specify Yes or No-	14. Race - Ameri	
ire, INTALYIEND ZIZIO-UUJO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, F 1 ☐ Yes 2 X No Specify:	-uerto nicari, etc.)	Black, White Specify:	BLACK
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and d be fi ental H eed of eed ot	To Be	RAHNAM DORSEY	LATI	ISHA HALL		
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- C - E		TERSIA HALL / GRANDMOTHER 3845	ST. BARNABAS RD		, , , , , , , , , , , , , , , , , , , ,	20746
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feco law re nas bee je 2 sho	Completed	·		24a. Was a autops perforr	med? prior to death?	topsy findings available completion of cause of
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or Attending after death. Director: After In by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s	M 1 ☐ Yes 2 ☐ Not treet, factory, office		treet and Number or Ri	ural Route Number,
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		Frances & Northington/X	Do0434	159	April 22	2009
		30. Name and address of person (who completed cause of death (Item 23a) (Typ		200 North Well	Ifo Ct. Doltier	ND 21207
	to	31. Date filed (Month, Day, Year) 32. Registrar's Ignatur		DUU NORTH WO	ile Si, Bailime	ore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Ignatur	-			

DHMH 17 Rev 1/2001

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Funera	ı	5. Social Security N	Number 6.	Sex 7. Ag	je (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month D 8/9/19	rth av. <i>Yeai</i>	9. Bi	rthplace (State o	or Foreign
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		23a Part Enter	the disease or cor	mplications that caused	the death Do		108 Will:					21811	Approximate	e
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	3 ☐ Suicide 4 ☐ Homicid <i>e</i>	6	28e. Place of Inj building, et	ury - At home, fa c. <i>(Specify)</i>	arm, str	eet, factory, office			28f. Location (City or To	Street a wn, Sta	and Number or F te)	Rural Route Num	nber,
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9416		0 0	ress of person who	completed cause of c	leath (Item 23a)	(Type,	Print)	to 1	B	elin M	0 2	2811		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2,4 APRIL Lisa Florence Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL BALTIMOPE WASHINGTON MEDICAL CENTE BURNUE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 X F 216-88-6242 35 18,1973 Director November Maryland Usual Residence of Decedent 10b. County show 10a, State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It — Medical Examination to the traumatic event, It — Medical Examination to the profile 2 at Director 1 Yes 2 No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1940 Cambridge Drive Funeral 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Unknown Florence Zachman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward M. Johnson/ Husband 1940 Cambridge Drive Crofton, MD 21114 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Lakemont Memorial Gardens 4 Donation 5 Dother (Specify) 4/29/2009 | Davidsonveille, MD 21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a nonsequence of) Examine It any teacher to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last g physician and as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performe certificate Division of Vital 1 □ Yes 2 No this certifical director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes / 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Registrar's Signature

APR 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HABATO Sor Hocpital Awite Glen Burne 31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Apr:1 2009 26 /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Center Dorchester (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 18-3610 1**Ø**M 2□ F Months Days Hours Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, inc. Medical Examinat must be notified at 1 ☐ Yes 2 No MD Director aston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 160 by Funeral KINS 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No. If Yes, Give World Year or Dates: Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT SKEEDER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev ပ RayMand 4Mel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ridge MD. Norma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 5/2/09 Richards Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HENRY FUNERAL Home, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ∐Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tinknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Diving Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident I Director: d in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the ...
To the Funeral Dire rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/6

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2009 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hesapeake Woods Center Dorchester If Under 1 Year If Under 14 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Oct. 34 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 102 M 20 F 218-30-094 Months Director 1934 Marylano Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No by Funeral Director Dorchester ambrida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U5.4 Iteme 23a 21613 eonard Lane death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1951 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify 3 Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be die beaver ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2
agestand of Health an Important: If I tem 27 is m any njury or other Cambridge Muid 20c. Location City or Town, State 419 MD,21613 Lane ouise Jones Leonard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ■Burial 2 □ Cremation 3 □ Removal from State 2 Condtown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address # Facility Panelle C. Glewy Henry Funeral Home, P. A.

23a. Party Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, smediate Cause (First). .21613 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) 40015 /Medical Due to (or as a consequence of): Examiner artery disease COVONAVY

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner ettending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No 1 ☐ Yes 1 Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify)

Medicai Certification; To Be Completed by

1 Yes 2 Yo 27. Manner of Death 1 Natural 2 Accident

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be

3 DOA 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

ress of person, who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month



28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

Division

23a or 28a-f show the Madical Examiner must be notified at deeth v filed within 72 hours etter 6 Baltimore, Maryland 21215-0036

pary Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Bobby Leon Jones April 26, 2009 8:20p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care of Chevy Chase Chevy Chase 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 229-30-7790 1**X** M 2 ☐ F 79 Yrs. Director April 6, 1930 Virginia Usual Residence of Decedent 10a. State D C 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Washington 1ÆYes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1937 Tulip Street, NW 20012 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 Tho
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maitred' Food Service 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be till Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event one. 18. Mother's Name (First, Middle, Maiden Sumame) Bernard Jones Dorothy Hendricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1937 Cecilia D. Jones / wife Tulip Street, NW, Washington DC 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 5/2/2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 7400 Georgia Avenue, NW, Washington DC 20012 indro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) physicien a s the burial-1 Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Sepsis 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown Completed Demetia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page Failure to thive certificate 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 200No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Alter 1XXNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funerei Director: . completely tilled in by the i 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai 11 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19609 April 26, 2009 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) 10810 Darnestown Road, Suite #202, Gaithersburg, MD 20878 Raman R. Tuli, MD 31. Date filed (Month) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

09-03434 Lynn Y. Kindred		I- For State	e ase Typ St	oe or Print in ate of Marylaı	nd / Depa	delible rtment o <i>tificate</i> o	of Heal	th and	All Co Menta	pies . al Hygi	Are Legi iene Reg		200)9
Physicia Medical Examir	ın/	Registrar 1. Decedent's Nam Lynn Y								1 1	Date of Death Month [April 29, 20	Day 09	Year	3. Time of Death 0201 hrs
		_	if not institution	n, give street and num	nber)		4b. City,		ocation of I		<u> </u>	4c. C	ounty of Deat ntgomery	n
Funeral Director		5. Social Security 1 044–34–	Number		7. Age (In yrs. Ia			er 1 Year	If Under 2	Min	Date of Birth		Forei	rthplace (State or gn puntry)
any	-	Usual Residence o	f Decedent 10b. County		10c. City,	Town or Loc	ation							10d. Inside City Limits
and show a	5	MD	Montg	omery	Poto	mac								1 Yes 2 X No
Baltimore, MD 21215-0036 Baltimore, MD 21216-0036 Department Pages I and La Should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nu					10f. Zip	p Code			109	j. Citizer	n of What Cou	intry?
with the	a D	10434 D 11. Marital Status	emocra	12, Was Dece	edent Ever in U.	S. 13. \	Nas Deced	854 ent of Hisp	oanic Origin	n? (Speci	fy Yes or No-		Race - Ame White, etc.	rican Indian, Black,
or item	Fune	r-	ed 2 X M	1 Yes	rces? 2 X No		f Yes, speci			-иепо кіс	can, etc.)	e,		hite
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5-0036 Led within 7 Hygiene. I other than	m o	17. Father's Name	(First, Middle	, Last)		Homer	naker	1	18.Mother's	Name (F	irst, Middle, M		Home umame)	
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Te, N 1 and 2 1 Health Fitem 2	ł	20a. Method of Dis	sposition		20b. I	Place of Dis	oosition (Na	ame of cen			Date			or Town, State
Baltimore, permit. Pages Lan Department of Her Important: If the		4 Donation 5	X Crematic	Specify:	JIII State	Arund	del Cr	emat					nton, 1	
Balt permit. Departi Import injury		21. Signature of E	/1 i/	/ // /	MO1	251 1	oing Sover		"Crem	atio	n Servi	ce	P.O.	Box 784
Physician		23a. Part I. Enter	ne disease, c	r complications that case on each line.	aused the death	. Do not ente	er the mode	of dying,	such as cal	rdiac or re	espiratory arre	st, shoc	k, or heart	Detween Onset and
/Medical kaminer		Immediate Cause or condition result	(Final diseas	Combine	d drugs	(Mep	eridi oxica		охусос	done,	and m	orpl	nine)	Death
		Sequentially list c		b			OXICA							
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Division of Vital Records, P.O. Box 68760, nother Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	an/M	IF FEMALE: 23b. Was deceder past 12 month		the 1 Live b	outcome of preg wirth ant at time of de	2	Fetal deat		Ectopic	pregnanc	су		Date of delive Month	ery Day Y ear
Box ne death the atte	Physici	1 Yes 2		9OIIKIN	own o death but not i				nivon in Par	et I	23e Did to	baccou	se contribute	to the cause of death?
P.O. es that the gened by be detach	by	Part II. Other sign		tructive p				ng cause ç	given in Fai					robably 4 🗸 Unknown
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of Vital Records, g Physician: The law requir the this certificate has been s meral director, page 2 should 1	omp										1 Yes	med? 2 No	death	
Vital Rec ysician: The I his certificate I	Be	25. Was case refe examiner?		Hoopital	Inpatient 2	ER/Outpat	ient 3	26.Place	of Death (Resider	nce 6 🗸 Ot	her: Scene
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sion trendir death. rtor: A y the fu	atio	1 Natural 2 Accident	5 Pe	nding Fd 4	/29/200			4III	Yes 2 X		unk	Stroot of	od Number or	Rural Route Number, City
Division of Vipital or Attending Phous after death.	Certification:	3 Suicide 4 Homicide	6 X Co	uld not be (Specify)	e of Injury - At I	l: res	idenc	e e	building, etc	i. I	or Town, S Cotomac	tate) I (3434 De	emocracy Lane
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the J		29a. Certifier	Certifying	Physician: To the bestaminer:On the basis	st of my knowled	dge, death o	ccurred at t	the time, d	late and pla	ice, and d	lue to the caus	e(s) and	manner as s	tated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 💌		and manner s	of examination stated.	and/or inves			se number		tile time, date			Month, Day, Year)
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922				on who completed cau tant Medical Exa		^{m 23a)} 1 Penn S	treet Ra	Itimore	MD 212	201				
S	tate	Ling Li, Mi 31. Date filed (Mo		7)7 0000 32. B	gistrar's Signa	turo d	,							
Regis			mai U	1 2003 /4	eneva	12.19	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jeanette Maxine Kelly /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hyattsville Manor Care Nursing Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **344–12–6110** Birthplace (State or Foreign Country)
 LOW a Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2**X** F Director April 16, 1924 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov the Medical Examiner must be notified at DC N/A Washington 1/3XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 United States 4402 13th Place, NE 'natural', or Items 23a by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes ZNo Baltimore, Maryland 21215-0036 Specify. Specify: Black 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Accountant Federal Government permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygis Important: If item 27 is marked other 1 any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McCoullough Kase Minnie Ella King 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place, NE, Washington DC20017 James K. Kelly 4402 13th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/4/2009 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McGuire Funeral Servie, Inc 7400 Georgia Avenue, NW, Washington DC 20012 Jusinsson indre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Holleties Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 2 XNo detached the 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably 4 Dinknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 2 No homie this certificate 1□ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes 4 Nursing Home ို 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Mann f Death 1 Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending within 24 hours after com.

To the Funeral Director: Aft

State

Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and

31. Date filed (Month

Registrar's Signature

F701 Randolph

29d. Date signed (Month, Day, Year)

1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4216, ROCKVILLE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 23 Day 2009 Year **Physician** 8:10A. M Margie \mathtt{Dell} Kirby /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sunrise Assisted Living Columbia Howard 5. Social Security Number 579-14-5110 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) Jan. 25,1920 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2**X**□ F 89 Nebraska Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Macical Examinat must be notified at once. Maryland Director Howard Columbia 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6500 Freetown Road 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 XNo Specify. If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary USDA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delphia F. Chase Millie Metz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie K. O'Hagan -daughter 8440 Jandy Avenue Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4/28/2009 SilverSpring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensel Bonala V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Disease years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physiclan: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate I perforn 24 No 1 ☐ Yes 2 No 1 🗆 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 XOther Assisted Lvg. Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m.D. D56531 April 24, 2009

Registrar
DHMH 17 Rev 1/200

State

31. Date filed (Month)

Market

Harry Li, M.D. 8600 Snowden River Parkway, #301 Columbia, Maryland 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: if Item 27 is marked other than "natural", or iteme 23a or 28a-1 ehow any njury or other traumatic event, it a Medical Examinar must be retitled at ODGs.	F	19a. Info	ormant's Na	me/Relations	hip (Typ	e, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	r or Aura	al Route Nur	nber, C	ity or T	own, State, Z	ip Code)	
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Division of Vital Records,	I or Attending P after death. Director: After i I in by the funera	Certification:	3 🗆	Suicide Homicide	6 Could determ	not be	28e. Place build	of Injury - At ing, etc. (Spec	home, farm, st					28f. Location City or	n (Stree Town, S	et and l State)	Number or Ru	ral Route Nur	nber,
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				N.	Tol	5~	1/7				14	197	X		4	4-	26-	200	9
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	Sta Registr	_	31. Date	filed (Mont	h, Day, Year)		32.	Registrar's Sign		- 40 4	,							East	/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 22, 11:45A M David Andrew Leggo April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2304 Porter Avenue Suitland Prince Georges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 **X**M 2 ☐ F 171-24-1519 26,1930 **Director** 78 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits pormit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exa. intermust be muffled at once. Y Yes 2 No Director MD PG Suitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2304 Porter Avenue Funeral 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 TXNo Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Andrews and Bolling Elementary/Secondary (0-12) College (1-4or 5+) Air Force Base <u> Heating Plant Engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Leggo Mary Petchel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 Porter Avenue Suitland, MD. 20746 19a. Informant's Name/Relationship (Type. Print) Marie Leggo/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4/24/09 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Park Crematory 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. P. rt1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slow, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Allentown Rd, #510, Camp Isaacs 5801 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day April 27, 2009 0601 hrs Medical Examiner LASSERY STEVEN 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Chevely 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) **Funeral** Foreign Count WASHINGTON Months Hours Director APRIL 1 1968 577-06-9352 1 X M 2 F 41 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No BLADENSBURG 28a-f shov PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20710 5015 60th AVENUE 這 Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married 2 Married AFRICAN AMERICAN 1 X Yes Widowed Divorced If Yes, Give Year Yes 2 X No specify: ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 other than PRIVATE Baltimore, MD 21215-0036 SECURITY GUARD 12TH of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) REV. CLARENCE L. JOYNER/ADOPTED FATHER PAMALA WARREN If item 27 is marked Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 6706 FAIRWOOD ROAD HYATTSVILLE, MARYLAND REV CLARENCE L. JOYNER/FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 XCremation 3 Removal from State RIVERDALE, MARYLAND RIVERDALE CREMATORY 5/7/2009 Other Specify: Donation 5 24 Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Parl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and √Medical Death Purulent pneumopleuritis Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine Enter Underlying Causa (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a, PII, 27, perME g892 6/8/09 TT XUNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy tending phy use as the b 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown ď Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive atherosclerotic cardiovascular disease; Completed page 2 should 24a, Was an 24b. Were autopsy findings available **Kyphoscoliosis** autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗸 Inpatient 2 Other₄ FR/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 Pending the 2 Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Could not be Suicide determined hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 30, 2009 MARA 30. Name and address of person who completed cause of death (Item 23a) Z Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Sanature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Mary D. Mark April 24 2009 6:30p 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy
If Under 1 Year | If Under 24 Hrs. Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🕅 F 218-26-3661 13,1929 Dec. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√TYes 2□No Maryland Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 90<u>7 McLendon Drive</u> 21702 United States 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2K No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) John S. Connor Import College (1-4or 5+) 12 Brokerage Liaison Services. Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Sedlak Theresa Zinner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Stone/ Daughter 2906 Jefferson Pike, Jefferson, Maryland 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 28/2009 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills Memorial Park Baltimore, Maryland 21. Signature of Feneral Service Licen Stauffer Funeral Homes P. A. Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DLON BYRS CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pa use contribute to the cause of death? ☐ No 3☐ Probably 4☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25 6 Bother (Specify) HOSTICE 27 HOUSE

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physician; Hospital or

and burial-trai attending physician the as nse been signed by the atte should be detached for i has certificate within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Examiner Physician/Medical ð Completed Be Certification: To Medical

Physician

/Medical

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Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, I'm Maryland Evaruate to context any liquity or other traumatic event, I'm Maryland Evaruate to an expectation of the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland Evaruate to the maryland E

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

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	ontributing to death but not resulting in the underlying cause given in Part I. RLIPIDE MA, DSTEDARTHRITTS	23e. Did tobacco use contribute to the cause of deat 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unk
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 Residence 6 Other (Specify) HOSPIC
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of lnjury 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ☐ Certifying Phr (Check only one) 1 ☐ Certifying Phr	rsician: To the best of my knowledge, death occurred at the time, date and place, a iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

MS nelson

29c. License number 121936

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICK, MD 21702 4. DONELSON, MD 65c THOMAS JUHNSON DK.

State Registrar

KB

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item State Registrar #26, per phys, 4/28/09, BA Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 6:05 PM George Randall Messix 04 2009 2 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Whaleysville If Under 1 Year 1 If Under 24 Hrs Workeste Hall oad Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1. M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Maryland Days 12/3/1953 55 215-48-1738 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Martal Hyglene. In Propagate, it flems 23a or 28a-f show Important: If flems 7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Martal Earn interval by mallified at 1X Yes 2 □ No Director MD Worcester Whaleyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11241 Hall Drive 21872 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 Tes 2 No 1 ☐Yes 2 ☐No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Service Restaurant Equipment Tech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Blades George Messix 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11241 Hall Road, Whaleyville, MD 21872 Michele Messix 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4/24/2009 Frankford, DE Cape Henolpen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signatur of Funeral Service 108 William Street, Berlin, Maryland 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rieta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading of including cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) i signed by the aid be detached for Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 NO မ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury Natural 5 Pending Hours after death. uneral Director: Af ely filled in by the fur 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b, Signatu re and title of certifie 29c. License numbe 30. Name and a ross of person who completed cause of death (Item 23a) (Type, Print) RAY amuelles 31. Date filed (Month, Day, 32. Registrar's Signature State Registra

ORIGINAL

DHMH 17 Rev 1/200

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** Month April 25, 2:30 P M Jane T. Malpass /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Montgomery Sandy Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2X F 95 1913 Virginia Director 214-32-7935 May 21, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In Inportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If a Medical Experiment must be refittled at once. Director 1 ☐ Yes 2 XNo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10214 Big Rock Road 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Completed by 3 ☐Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Owner Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Pickett Levy Lola Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10214 Big Rock Road Silver Spring, MD 20901 Dennis Malpass/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 04/29/09 21. Signature of Funeral Service Licensee Going Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Waldenstrom's Macroglubulinemia years /Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Sick Sinus Syndrome the attending physician and hed for use as the burial-tran years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Osteoporosis years IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ KProbably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has performed? 1 □ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐Yes 2 ☐ No ours after death. death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled 29a. Certifier l 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6)02

State Registrar

29b. Signature and title of certifier

Glancy III, M.D., 1731 Briggs Chaney Rd. Silver Spring, MD 20905 32. Registrar's Signature

30. Name and a dress of person who completed cause of death (12 m 23a) (Type, Print)

and manner stated.

29c. License number

D25345

29d. Date signed (Month, Day, Year)

April 27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 **Physician** Apri William Algie Marshall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7all00+ saston Memorial 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 06-01-1959 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Days Hours Months Maryland 49 135-56-3196 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 200. The Maryland any injury or other traumatic event, the Maryland ones. 10a State 10h. County 10c, City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Md. Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 USA 305 Crusader Rd., Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Detailer Carwash 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Howard Wheatley Marshall Rosemary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Angelina Cephas Marshall, 305 Crusader Rd.,Apt.6,Cambridge,Md.21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 104-30-09 Cambridge.Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 524 Race St., Cambridge, Md. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer MOS Liver disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physlcian: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ Helants 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. P.O. Records, of Vital filled in by the funeral Division death. after death 24 hours a Medical

completely within 2 To the +VA

State Registrar

31. Date filed (Month, Day, Year)

4 Homicide

29b. Signature and title of certifie

Dand

29a, Certifier

30. Name and address of person who completed cause of death (Hom 23a) (Type, Print)

8221

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

29c. License number

D66270

29d. Date signed (Month, Day, Year,

Easton, MD

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		•	For State Registrar	Otato of many tank		te of Death	Reg	. NZ. 0 0 9	15349
	Physici /Medic	7	1. Decedent's Name (First, Middle, Last Elizobet	2 (4)	a Mar	oKey	2. Date of Death Month April	Day Year	
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	Funeral Director		440-74-7436		Viter Visual In Uncompanies Month	Jer 1 Year If Under 24 Ars s Days Hours Min.		Dorck (ear) 9. Bir 1936 N	thplace (State or Foreign country) laryland
	aryland show dat	_	Usual Residence of Decedent 10a. State 10b. County		y, Town or Location	1 1			10d. Inside City Limits
3	or 28a-f	Directo	10e. Street and Number	hester	Cambr.	Zip Code)	109	g. Citizen of What C	ountry?
5	a 23a	eral [P. O. BOX 47	12. Was Decedent Ever in U	S 13 Was De	2/6/3	Specify Yes or No-	14. Race - Am	ncan Indian.
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Montal Hygiene. If it em 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, it is Maralcal Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2 Specify:	to Rican, etc.)	Black, Whi	
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bu	be filed tal Hygir d other event, I	Be	17. Father's Name (First, Middle, Last)	. 44		18. Mother's Na	me (First, Middle, Ma		,
Maryland	2 should be and Mental Is marked o aumatic eve	ဥ	19a. Informant's Name/Relationship (T		anoKey 19b. Mailing Addre	ess (Street and Number or R		Todd City or Town, State,	Zip Code)
_	1 and 2 s Health ar Iom 27 is		Geneva S	Stanley	400 E. J	Dover St. Apt	.206 Ea	5 / 0 / M	D.21601
Baltimore	Pages 1 nent of H nt: If ite ry or ot		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	d Field (r other place)			eek, MD.
Balti	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licens		00 11	and Address Facility LY FUNERAL WOSHINGTO			/
	- a		23a. Part1 Enter the disease, or comp	lications that caused the deal	Do not enter the m	node of dying, such as cardia	ic or respiratory arres	st,	Approximate Interval Belween
N.	Physician		Immediate Cause (Final disease or condition resulting in death)	a cerebral v	25 aulau	accident			204625
	/Medical Examiner			Due to (or as a consect NEUTOCOL	quence of):	ohasia			20 years
	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):	J'			1
o,	e be execut /sician and e burial-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):				
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P.O. Box 6	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3 Ectopic	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
s, P.	uires that the der signed by the a id be detached f	by Ph	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.			to the cause of death?
ord	w require been signatured by	eted	seizure diso				1 ☐ Yes 24a. Was an		Probably 4 Unknown
al Rec	The ta ate has page 2	Completed by					autopsy perform 1 Yes 2	prior to death? No 1 \(\sqrt{Ye}	autopsy findings available completion of cause of
Z.	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3[]	100	eath (Check only one Home 5 - Resider		ecify)
n of	ing free free free free free free free fre		27. Manner of Death 1 Anatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe hor		
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		nome, farm, street, factify)	1 Yes 2 No	28f. Location (Str. City or Town,		Rural Route Number,
٦	Hospital 24 hours a Funeral I	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	ysicien: To the best of my kniner: On the basis of examination and manner stated.	ation and/or investigat	ion, in my opinion, death occ	curred at the time, da	use(s) and manner te and place, and de	as stated. ue to the cause(s)
	To the within ? To the somple	Mec	29b. Signature and title of certifier	and manifer stated.		29c. License number	29	d. Date signed (Mo	
	h		Deparson a	gu		H00599	73	4/24/0	13
	N		30. Name and address of person who of	completed cause of death (Ite	m 23a) (Type, Print)	nbridge M	0		
物	Sta Regist		31. Date filed (Month, Day, Year)	32. Régistrar's Sign	ature	29c. License number HOO 599 Mbridge M			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 23,2009 1433 м **Physician** Harold Ρ. Mikules /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 4 (Month, Day Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Washington DC 1 X M 2 □ F 92 579-03-1721 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other than unit or own, I' 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🛛 No Director Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA Funeral 800 Bestgate Road 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√∑ No Specify: Specify: White Completed by 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Fire Department FireFighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mikules Crodellia Kelly ပ Alexander Leon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4725 Ringwood Meadow Sarasota, Florida Thomas L. Mikules Son Department of Health Important: If item 27 any injury or other to 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 4/27/09 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Brentwood, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD Jab 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the nor de of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (ome Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown signed l d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Hospital or Attending Physician: The SZNO 1 ☐ Yes 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 🗖 1 ___npatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Ertifying Phy ci n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Exa net: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) **APR 28** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mans /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomes 9. Biblipplace (St 8. Date of Birth Aug. 12, **Funeral** last birthday Min. 1 □ M 2 🛛 F Months Days Hours Russia 93 Director 021-16-2838 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has a 72 is marked of the than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner mast be mailtied at 1 TYes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 United States Funeral 807 Horton Drive 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: white Specify 2 3 ☐XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moise Ganapolsky Esther Fira Ganapolsky 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Mansfield, Son 807 Horton Drive, Silver Spring, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of Important: If Ite any injury or ot 1 🕅 Burial 2 □ Cremation 3 🖾 Removal from State 4 Donation 5 Other (Specify) 04/27/09 Wellwood Cemetery Pinelawn, LI, NY 21. Signature of Fundal Service Cicent Torchinsky Hebrew Funeral Home Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to r as a consequence of): / /Medical Examiner DORKS Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit certificate be executed o wontic $\mathcal{N}\mathcal{K}U\mathcal{O}\mathcal{O}\mathcal{O}\mathcal{L}$ Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **(** No 1 ☐ Yes 2 ☐ No of Vital 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direc Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficiency in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

3

MANSFIELD

State Registrar 29b. Sigpature and title of certifier

Somuru

30. Name and address of person (vh) completed cause of death (

28

8600

29c. License number

Old Georgebown Rd

Physician
/Medica
Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Model Examinar must be retified at any office.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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	1	1 - State Registrar	C	Certificate of I	Death	Reg.	No. 2009	10002		
ician dica		1. Decedent's Name (First, Middle, Last) CATHERINE MARIE MAR	TIN			2. Date of Death APRIL 2	2°, 200°9°	3. Time of Death 8:30 PM		
ine		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		Silver	Location of Death Spring If Under 24 Hrs.		4c. County of Deat	IERY		
al or		1 N OFF	80 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye July 11	9. Birt ,1928	hplace (State or Foreign untry) Wash. DC		
Director	- 1	10a. State 10b. County 1 MD Montgomery 1	Oc. City, Town o	Silver S	pring			10d. Inside City Limits 1 □Yes 2X No		
O les		10e. Street and Number 1102 Devere Drive		10f. Zip Code 209()3	10g.	10g. Citizen of What Country? U.S.A.			
hy Emoral	2	11. Marital Status 1. Marrital Status 1. Was Decedent Ever Armed Forces? 1. □Yes ≥ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.		
Completed	ompiere	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Yrs	- (G	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired Administ	during most of work d)	ing]	Plumbers & Pip Fitter U.A.			
a a	ם -	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Mai	den Surname)			
Ĕ		John Edmund Martin			Mitzi	e Falen	tin			
		19a. Informant's Name/Relationship (Type. Print) Mazie Olga Kitts (Sist	er) 12		or Dr.,	Woodbri	dge, VA	22192		
1		1 □ Seurial 2 □ Cremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify)		isposition (Name of crematory or other place of Heaven	Cem 4/2	19/09 S		oring, MD		
Silo		21. Signatur of Funeral Service Licensee	uch	22. Name and Addre				ME, P.A. MD 20850		
n al	d.	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Menta Due to (or as a c	1 Stat	us Change		Approximate Interval Between Onset and Death				
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ر ام بط	- Ka 25	Part II. Other significant conditions contributing to death but r	not resulting in th	ne underlying cause giv	en in Part I.		oid tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
Completed by Physician	non-line		d? death?	utopsy findings available completion of cause of						
B	3	25. Was case referred to medical examiner?		l ou		h (Check only one)				
Medical Certification: To		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Y) 2 ☐ Accident Investigation	28b. Tirr	ry Wor	4 LI Nursing Ho		Residence 6 Other (Specify)			
Certific		3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	et and Number or Ri State)	ural Route Number,						
legipe	5	29a. Certifier (Check only one) 12 Certifying Physician: To the best of a Medical Examiner: On the basis of examt manner states	xamination and/o	death occurred at the ti or investigation, in my c	me, date and place ppinion, death occur	and due to the cau	se(s) and manner a and place, and due	s stated. e to the cause(s)		
Me		29b. Signature and title of certifier		29c. Licens	e number	29d	Date signed (Mont			
		30. Name and address of person who completed cause of deat			0672	79	4/23/0			
State		Suganthi Alagarsamy, M. 31. Date filed (Monthly) 28 2009 32. Registrar's	1.D. 15 s Signatur	ball	t Glen I	ka, Silv	er Sprii	ng,MD 2091		

Registrar

			Please T	ype or Prin								
			For State	State of Ma	ryland /	•	tment of F ificate of i		-	_	0000	15253
			Registrar 1. Decedent's Name (First, Middle, Last)			ilicale of i	Dealii	Reg. No. 2			3. Time of Death	
	Physicia /Medic		Kenton	Ear1		Morga	an		Month	D	2009 Year	7:30 Pm
· Car	Examin		4a. Facility Name (If not institution, give	street and number)				r Location of Death	1		c. County of Deat	
2			8429 Poplar Hill I	Drive			Clinton				rince Ge	
	Funeral		5. Social Security Number 6. Sex	1M 2□ F	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	ıv. Yea	r) Co.	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	XX ^{2□ F} 6	7	115.			March	30,	1942 Ok	Lahoma
	and m		10a. State 10b. County		10c. City, Tov	vn or Loca	ation					10d. Inside City Limits
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	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, White	
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lar	permit. Fages 1 and 2 should be Department of Health and Markenta Important: If Item 27 Is marked any Injury or other traumatic evente.		19a. Informant's Name/Relationship (Ty			_					or Town, State, 2	
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			shock, or neart failure. List only or Immediate Gause Final	ne cause on each line).		-	•			1016	Interval Between Onset and Death
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Vital Records	as be	Completed	DEEP VE	IN THI	20m	B0-	212		24a. Was		24b. Were au	utopsy findings available completion of cause of
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_	After After funera	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b.	Time of Injury	28c. Inju Wor	ryat ′k?]Yes 2 ∐No	28d. Describe	how in	jury occurred	
SIS	Attending or death. ector: Afte by the fune	icat	Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ry - At home	farm stree		Tes 2 110	28f Location /	Street	and Number or Ri	ural Route Number,
DIVISION	after Direct	Certification	4 ☐ Homicide determined	building, etc.	(Specify)	ionini, on o	ot, rabioty, omos		City or To	wn, Sta	ate)	
	To tre nospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun			sician: To the best o								
	in 24 in Period	Medical	(Check only 2 Medicel Exami	Iner: On the basis of and manner sta		and/or inve	estigation, in my	opinion, death occ	urred at the time	, date a	and place, and due	to the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier	MS			29c. Licens		0-1		Date signed (Mont	
			Seg				7	181	2	AT	RIL 2	4,2009.
5	BINEL		30. Name and address of person who co	PS 9131	PISC	(Type, P	rint)	CUN	MMM	D	2073	5
	Sta Registr		31. Date filed (Month, Day, Yeer) APR 28 20	32. Registra	r's Signature	40	ake					

		1 - For State Registrar	State of Marylar		rtificate of		F	Reg. No. 2	9 15351
Physic /Med		Decedent's Name (First, Middle, Le ANNAH LEE MULL					2. Date of Dea Month APRIL	Day Yea 26, 2009	
Exami Funera Director	ner	231-20-4676	D HOSPITAL	. last birthday) Yrs.	4b. City, Town, o CLINTON If Under 1 Year Months Days	r Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da) OCT. 13	h 9. I	GEORGE S Birthplace (State or Foreign Country)
faryland show	o	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Markeal Eventies must be notified at	al Director	MD PRINCE 10e. Street and Number 3007 RAYMOND CT.	GEORGE'S FT	. WASH	10f. Zip Code 20744			10g. Citizen of What	Country?
Irs after dea	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:	[Was Decedent of H If Yes, specify Cub 1 □ Yes 2 🛣 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Specify:	omerican Indian, Inite, etc. WHTTE
rithin 72 houne.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(Give		pation during most of work d)	king	16b. Kind of Busine	ess/Industry
ld be filed w lental Hygiel ked other ti ic event, th	To Be Col	11TH 17. Father's Name (First, Middle, Last GEORGE W. WEEKS)	WAIT	RESS		e (First, Middle, CE SPELL	Maiden Surname)	/PHILLIPS
and 2 should ealth and Mer n 27 is marke		19a. Informant's Name/Relationship PATRICIA MARIE NO	RMAN/DAUGHTER	3007	RAYMOND	CT. FT.	WASHING	er, City or Town, Stat	20744
Pages nent o int: If		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y) FT	. LINCO		ERY 05-0		BRENTWOOL	O, MD
permit. Departr Imports any inju	Yi:	21. Sunato of Funeral Service Lice 23a. Part 1. Enter the disease, or con	Slen	7	4308 SUI	TLAND RO	AD SUI	TLAND, MD	Approximate
Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. Due to (or as a consection)						Interval Between Onset and Death
cate be executed by sician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.	quance of):	el fensi				Years
the death certifi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	gy		23d. Date of Month	delivery Day Year
equires that sen signed to	þ	Part II. Other significant conditions Renal (ell	contributing to death but not re Concinoma Kidney fai	sulting in the u	inderlying cause giv	ven in Part I.			te to the cause of death?
n; The law r ficate has be r, page 2 sh	Completed	CAD	Kianey fai	lure	on dia		perfo 1 □ Yes	prior prior death	e autopsy findings available to completion of cause of h? Yes 2 □No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 DNO 27. Manner of Death 1 DNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined.	e laco of Injury . At h	28b. Time of Injury	of 28c. Inju Wor M 1	ry at	ome 5 ☐ Resid	dence 6 Other (s	Specify) r Rural Route Number,
e Hospital 24 hours a e Funeral	Medical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, dear nation and/or in	th occurred at the to	ime, date and place opinion, death occu	and due to the rred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	ndhuml	MD	29c. Licen:			29d. Date signed (M	onth, Day, Year) 2 8 Eh , 200 C
	ate	30. Name and address of person who RAVINDER SINDHWA 31. Date filed (Month, Day, Year)	NI 7503 SURI	RATTS R	OAD CLI	NTON, MD	20735		
Regist		APR 2.9 200	A Property A	hou	Call .				

DHMH 17 Rev 1/2001

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** VIVIAN S. NEMETH 23 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WILLIAM HILL GARDENS EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1916 Days Months Hours 92 Director 179-16-6352 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10c. City, Town or Location 10a. State 10b. County Director MD TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 545 CYNWOOD DR. 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ② If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Completed by 3 XXidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOREN B. SMITH ဥ LOUISE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE J. NEMETH SON 5005 BRIDGE POINTE DR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 XX emation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 4-24-2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENEBIN & NEWNAM FUNERAL HOME, P.A. Strowski CF.S.P. 200 S. HARRISON ST. EASTON, MD 21601 M Soseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examine or Attending Physician; The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, iis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown death-but not resulting in the underlying cause given in Part I. δ 1 Tes Be Completed 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

CHESTER, MD 21619 20c. Location - City or Town, State STEVENSVILLE, MD Approximate Interval Between Onset and Death Secones no 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2009

14. Race - American Indian

Black, White, etc.

4c. County of Death

TALBOT

USA

Specify:

710 P

Birthplace (State or Foreign Country)

WHITE

10d. Inside City Limits

XXYes 2 No

State Registrar

in by the funeral

After 1

after death Director:

To the Hospital o within 24 hours aft To the Funeral Di filled i

4

27. Mann of Death

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certific

31. Date filed (Month, Day,

5 Pending investigation

6 □Could not be

APR 28 2009

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 - For State Registrar

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

			For	State of I	Maryland / Depa	artment	of H	ealth a	and Me	ental Hy	gien	е	
		1 - State Registrar Certificate of Death Reg. No 19										15356	
			1. Decedent's Name (First, Middle, Last) 2.									ay Year	3. Time of Death
	Physici /Medic		William	William F. O'D						Month April	23,	2009	12:00 A M
Vi.	Examir		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, T	own, or	Location o	of Death	-	40	c. County of Death	
*			Manor Care Poto	mac		If Under 1		tomac				Montgom	
	Funeral	uneral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						if Under	24 Hrs. Min.	Date of Bir (Month, Da	th <i>ly, Year</i>	9. Birth Cou	place (State or Foreign ntry)
	Director		578-20-0776	TX W ZUF	87 Yrs.					Feb.26	,192	22 Wash	ington,D.C.
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Limits
	laryis sho	ō	MD Mantas		Detemas								1∭Yes 2□No
	the N	ect	MD Montgo	omery	Potomac	10f. Zip 0	Code				10a. C	itizen of What Cou	ntry?
	with a or	Ö		m			854					.S.A.	
	ns 23 mus	era	10714 Potomac 1	12. Was Decede	ent Ever in U.S. 13.	Was Decede	nt of His	spanic Ori	gin? (Spe	cify Yes or No		14. Race - Ameri	
' O	r iter	Funeral Director	1 ⊠Never Married 2 Marrie	Armed Force 1 1 Yes 2 If Yes, Give		If Yes, speci			i, Puerto F	Rican, etc.)		Black, White	
036	ursa al''o Exam	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es: WWII	1 ☐ Yes 2	K No	Specify:				Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifiled at	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual	Occupa	ation	t of workin	aa	1	Kind of Business/Ir	•
21	an "re	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	kind of work DO NOT use				9	Rom	an Catho	
21	er th	Con		5+	Catho	olic P						Churc	n
nd	d oth	Be	17. Father's Name (First, Middle, L	ŕ						(First, Middle	, Maide	n Surname)	
yla	Men Men arke	2	William F. O'l						rtruc				
Maryland	2 sh and Is m		19a. Informant's Name/Relationshi								-	or Town, State, Zi	p Code)
6)	l and lealth im 27 her t		Stephen O'Donne	11/Nephew	20b. Place of Dispo							Location - City or T	own State
0	it of H		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Sta	cemetery, cre	matory or otl	ner place	e) A	April				
Baltimore,	t. Partant:		4 Donation 5 Other (Sp.		Mt. Olive	2. Name and		o of Englis	200			shington,	р.с.
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	000/10	/				DC			al Home	20007
			23a. Papt . Enter the disease, or o	complications that cau								h., D.C.	Approximate
	₽.		shock, or heart failure. List of immediate Cause (Final	nly one cause on eac	h line.	tor tire mode	or ayını	g, odom do	our dido o	. roop, alony a			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		rdial Infarc	tion							
7	Examiner				ary Artery D	icono							
	1.00	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence of):	ISEASE	-						
	uted d ansit	ᆵ	cause. Enter Underlying Cause (Disease or injury that initiated events	٧.									
Ć.	exec in an	Examiner	resulting in death) Last	Due to (or	as a consequence of):								
8760,	requires that the death certificate be executed seen signed by the attending physician and nould be detached for use as the burial-transit	dical		d									
9	tifical ng phy as th	ledi											
Box	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregnancy h 2 □ Fetal death 3[□Ectopic pre	enancy					23d. Date of deliv	
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar 9□Unknow	nt at time of death 5	Other (spe						Month	Day Year
P.0	w requires that the death certifit been signed by the attending I should be detached for use as	Physician/Me	9 Unknown	l						00- Did			the cause of death?
	ignec be de		Part II. Other significant condition		th but not resulting in the u	inderlying ca	use give	en in Part i	•				bably 4 Unknown
orc	requi	ted	Alzheimer's Dis	ease							163	2 <u>M</u> 100 3 <u>0</u> 110	———————
ec	law las be	ple								24a. Was	psy	prior to c	topsy findings available ompletion of cause of
H	The laste has page	Completed by								1□ Yes	ormed?		2 No
/ita	clan: ertific	Be	25. Was case referred to medical examiner?	Lienitel					e of Death	(Check only	one)		
O.	Physiclan: r this certific ral director,	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp				412111				6 □Other (Spec	eify)
n	After Uner	o U	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Injury 28b. Time of Injury		Bc. Injury Work			28d. Describe	now inj	ury occurred	
Sic	Attending r death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	ot be 280 Biago o	f injury - At home, farm, st	M reet factory		Yes 2□		ogf Location	(Street	and Number or Ru	ral Route Number,
Division or Vital Records,	or A after of Direction by	Certification:	4 ☐ Homicide determin	building	, etc. (Specify)	reet, lactory,	Onice		1	City or To	wn, Sta	ite)	rai Progra Prambal,
	pital ours a leral filled	2	29a. Certifier 112 Certifying	Physician: To the b	est of my knowledge, dea	th occurred a	at the tin	ne, date a	nd place, a	and due to the	cause	(s) and mariner as	stated.
	the Hospital hin 24 hours a the Funeral I	Medical			is of examination and/or in								
	To the Hospital or Attending Physician: The law within 24 hours after cleath. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier			29c.	License	e number			29d. E	Date signed (Month	n, Day, Year)
	5+1		1) -11	m	ッ	D31	5579			Apr	il 23, 2	009
	J 1 1		30. Name and address of person v	/ho completed cause	of death (Item 23a) (Type	, Print)	J- J-					, _	
			Susan J. Miller	, MD_8218	Wisconsin A		Bet	<u>the</u> sd	a, M	20814	4		
		ate	31. Date filed (Month, Day, Year)	32 Rec	strar's Signature	1 .							
	Regist	rar	HER Z	8 2009	eneur B. x	Backe							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Linda Lorraine Gosule Parker 3:10p M April 13, 2000 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, April 7, 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🕱 F 021-36-1049 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2XXNo Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 USA 3008 Shepperton Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Black, White, etc. ☐Yes 2 Yes, Give 2**X** No 1 Never Married 2 Married 1 □Yes 2XXNo Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Adult Day Care Center Activities Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanford Lorraine Smith Barbara Ellen Maquire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bethany G. Ridgely / Daughter 715 Brookridge Drive, Boonsboro, MD 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State April 14, 2009 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Fyneral Service Wonse 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 - Lako 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Respiratory Acidosis disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Exacerbation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Pneumonia Due to (or as a consequence of). yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

7 Is marked other traumatic event, #

and Mental

Health a

permit, Pages 1 and Department of Health Important: If item 27 any Injury or other troone.

Director

Funeral

þ

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trar the. attending pl signed by the a been si certificate has birector, page 2 sl director

Hospital or Attending Physician: The law requires that the death certificate be executed

this

After

after death

Director: /

i 24 hours af e Funeral Di fetely filled in

To the Hosp within 24 hou To the Fune completely fi

Medical

Division of Vital Records, P.O. Box 68760,

Examir Physician/Medical ð Completed Be Certification: To 27. Manner of Death

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No 9 Unknown 25. Was case referred to medical examiner?

1 Tes 2 No

1 XNatural

2 Accident

4 Homicide

3 ☐ Suicide

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 XNo

				26.	Place of Dea	th (Check only one)
spital:	1 ☑ Inpatient 2 □] ER/Outpatient	3 □	DOA Other: 2	1 ☐ Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
	Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? -1 □Yes		28d. Describe how injury occurred
28e.	Place of Injury - At h	ome, farm, stree	t, facte	ory, office		28f. Location (Street and Number or Rural Route Number City or Town, State)

29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

Но

29c. License number

D 00P

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suganthi Alagarsamy Veerappan

APR

9000 Franklin Square Drive, Baltimore, MD 21237

State Registrar 31. Date filed (Month, Day, Year) Registrar's Signature 16

			State of Marylan		artment of F rtificate of I		•	200	0 15358
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	Tillicate of t	Jeain	2. Date of Dea	ath	3. Time of Death
	hysicia /Medic		Florence Gertrude Pontier		3:22 P ^M				
*	xamin		4a. Facility Name (If not institution, give street and number)	4c. County of I	Death				
and the same			Fahrney Keedy Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs.)		Boonsbo		0 D-1f Bi-t	_	ton County
	neral ector		5. Social Security Number 6. Sex 7. Age (In yrs. 1 1 1 M 2 1 F 83	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Sep. 2	y, Year) 1.1925 N	Birthplace (State or Foreign Country) ew Jersey
			Usual Residence of Decedent				DCP. 2	1,1723	
larylar	suov ed at	ō	10a. State 10b. County 10c. Cit Maryland Washington County Boon	y, Town or Lo	cation				10d. Inside City Limits 1 □Yes 2 🕅 No
the M	notific Total	rect	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	
pail(IIIIOre), Maryland 21215-5-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	let be	Funeral Director	8507 Mapleville Rd.		21713			U.S.A.	
er dea	rems rems	uner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
rs afte	Warnin	by F	1 DXNever Married 2 ☐ Married 1 ☐ Yes 2 DXNo If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	I∐Yes 2∏No	Specify:		Specify:	White
5-UUSD 72 hours aft	iarura ical E		15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of Busin	ess/industry
ithin 7	nan l	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	9		during most of worki l)	ng	DL	
illed wi	int, the	S	12 17. Father's Name (First, Middle, Last)	Secre	etary	18. Mother's Name	(First, Middle,	Maiden Surname)	utical Co.
Viand	ic eve	To Be	Leonard Pontier				,	t Pontier	
Mary d 2 shou th and N	aumat		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street			er, City or Town, Sta	te, Zip Code)
and 2	her tra		Paul Mauriello-nephew				-	town, MD	
ages 1	orot		1 Burial 2 La Cremation 3 Li Removal from State 1	•	sition (Name of natory or other plac		ate	20c. Location - City	
Dalling Dermit. Pages Department of	injury		4 □ Donation 5 □ Other (Specify) Smi 21. Signature of Funeral Service Licensee			ory 4-30		Smithsbu	rg, MD uneral Home
Dep 1	any ir	5 0	Duncton & Time						n, MD 21742
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between
Physi		8 3	Immediate Cause (Final disease or condition	nonar	y Arres	t			Onset and Death
/Med Exam	dical niner		resulting in death)	uence of):	Talic .				
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	uence of):	100 1157	1			+
cuted	ransit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
icate be executed physician and	urial-t	Ē	resulting in death) Last Due to (or as a consequ	ence of):					
icate physi	s the burial-transit	dical	d						
n certi	for use as t	N/N	IF FEMALE: 23c. If yes, outcome of pregnant		1			23d. Date o	f delivery
death	ed for	Physician/M	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		Ectopic pregnancy Other (specify)	/		Month	Day Year
hat the	letach		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resu	ulting in the ur	derlying cause give	an in Part I	23e Did to	hacco use contribu	te to the cause of death?
Ords, requires the	dbe	d by	Tarth. Other significant conditions contributing to dead but not resc	ining in the ur	denying cause give	sirini i care i.			Probably 4 🛱 Unknown
w requ	shoul	lete					24a. Was	an 24b. Wer	e autopsy findings available
The la	age 2	Completed					autop perfor 1 □ Yes	sy prio med? deal	r to completion of cause of
cian;	ector, p	Bec	25. Was case referred to medical examiner?			26. Place of Death			163 2 1110
Physic Physic	al dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 □			4 Languarsing Ho		lence 6 Other (Specify)
ding Affer	funer	tion	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	yat :? Yes 2 □ No	28d. Describe r	ow injury occurred	
Atten ar deal	by the	Certification:	3	me, farm, stre			28f. Location (S	Street and Number of	r Rural Route Number,
tal or rs after al Dir	ed in	Cert	a Tronicae building, etc. (Specif)				City or Tou	n, State)	
To the Hospital or Attending Physician: The law requires that the death certifuling 4 hours after death. To the Funeral Director: After this certificate has been stoned by the attending.	letely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and mann- date and place, and	er as stated. due to the cause(s)
To the Within	comp	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (A	lonth, Day, Year)
			Momas Cilbert D.	U. PACO	# 1440	0884		05/01	13009
5H-10	0		30. Name and address of person who completed cause of death (Item Thomas Gilbert 251 E. Avita	23/a) (Type, 1	St. Hag	erstown	MD.	21740	
Ro	Stat egistra	_	31. Date filed (Month, Day, Year) MAY 0 1 32. Registrar's Signar	ture	ad				
				-					

dress of person who completed cause of death (Item 23a) (Type, Print)

ACHTCHIN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

20c. Location - City or Town, State Vietnam Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 PNo 2 □ No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2000 7600 Carroll Avenue Takoma Park, MD 20912

43

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Vietnam

Race - American Indian, Black, White, etc.

Asian

2004

4c. County of Death

Montgomery

Specify:

State Registrar 4 Homicide

(Check only one)

31. Date filed (Month

29b, Signature and Me of certifier

APR 2

29a, Certifier

Medical

DHMH 17 Rev 1/2001

within 24 hours after To the Funeral Direct

10+1

29c. License number

		For State Registrar	State of N		d / Dep		Health and I	Mental Hy			15360
		Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
Physicia		YCHIT	CAROL 1	- PALMER				Month April	24,	Year 2009	12:15 AM
/Medic Examin		4a. Facility Name (If not institution, given			1	4b. City, Town, o	or Location of Death			unty of Death	
LAGIIIII	Ci	Frederick Memor	rial Hoen:	ital		Freder	rick		Fre	ederic	Σ
Funeral		5. Social Security Number 6. S	Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th v. Year)	9. Birth	place (State or Foreign ntry)
Director		213-46-7132	I□M 2131F	6	2 Yrs.	Months Days	Tiouis Willi.	Oct. 7,	1946_	Virg	
pu.	-	Usual Residence of Decedent 10a. State 10b. County		100 City	y. Town or Lo	ocation					10d. Inside City Limits
aryla shor	5	Toa. State Tob. County		100. 01	y, TOWIT OF E	ocation					1⊠Yes 2□No
the M	Director	Maryland Frederi	.ck		Fred	lerick 10f. Zip Code			10a Citizen	of What Cou	ntry?
with	ā	106. Street and Number 10f. Zip Code 10g. Citizen of What 10g. Trip Code 21701 United									
ns 23	Funeral	701 Toll House Av	12. Was Deceder	nt Ever in U.	S. 13.			pecify Yes or No		Race - Ameri	
r iter d	五	1 ☐ Never Married 2 ☐ Married	Armed Forces	?			Hispanic Origin? (S ean, Mexican, Puert	o Rican, etc.)			
al",o	þ	3 ₺ Widowed 4 □ Divorced	If Yes, Give Year or Dates	s:		1 ∐Yes 22 ⊠ No	Specify:		Specify: White		
72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occu	pation	rkina	16b. Kind	of Business/Ir	ndustry
ithin Jan "	ğ	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use retire	during most of wor	9			
led w lygien her th	S	12	,			Care Pro		/Final Adiable		-Profit	
be fi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan		Maiden Sui	mame)	
2 should be filed within 72 hours after death with the Maryland rand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ဍ	Travis Vaught 19a. Informant's Name/Relationship	(T. e. Orien)		405 Mail	Add (Ct	t and Number or Ru	Davis	or City or Tr	Ctota 7	n Codo)
d2st than 7 Isr traur		Tiffany Fossett /	, ,			5	Drive, I				p Code)
1 an Heal tem 2		20a. Method of Disposition				osition (Name of matory or other pla				ion - City or T	own, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination in the Colling at once.		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Opeci		e		matory or other pla 1 Cre mato	, .	Ll ^{Date} 25, 2009	Frador	ciak N	Maryland
ortar Portar Injur	-	21. Signature of Eurieral Service Lice		Kes			ess of Facility Funeral S				
Depar Impol any Ir		+KA/			Re	esthaven 501 Catoc	funeral S tin Mtn.	Services Hwv. Fr	, Skko ederio	ot Cody ck. MD	7 P.A. 21701
		23a Part I. Enter the disease, or com	plications that caus	ed the death							Approximate interval Between
Physician		Immediate Cause (Final disease or condition	//	1 New		Eusenl	nalocat	hn.			Onset and Death
/Medical		resulting in death)	Due to (or a		uence of):			X			
Examiner		Immediate Vause (Final disease or condition resulting in death) a. Aucroic Encephalopathy Due to (or as a consequence of): Ventrousiar Filosofications b. Ventrousiar Filosofications									Hours
sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequ	uence of):						
be executed ician and burial-transit	хап	that initiated events resulting in death) Last									
bur icis	E E										
feath certificate attending physic for use as the k			_ d								
nding use a	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			_			23d	I. Date of deliv	very
death death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth	et time of d		☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су			Month	Day Year
ires that the de signed by the be detached	Physician/Medio	9 Unknown	9 🗌 Unknowr	1							
es the	by	Part II. Other significant conditions contributing to deal roll resoluting in the discerning dates given in Fart.									
w require s been si should t	ted	End Stage	Ronal	n, sea	52			1 🗆	Yes 2	No 3∐ Pro	bably 4 Unknown
law las b	ed l							24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
: The	Completed							perfo 1 □ Yes	2 No	death? 1 ☐ Yes	2 □ No
icertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			LOH	26. Place of Dea	ath (Check only	one)		
Phys	유	1 Yes 2 No 27. Manner of Death	28a. Date of Ir		ER/Outpatie 28b. Time of	nt 3 L DOA	4 LI Nursing F	lome 5 ☐ Resi 28d. Describe			ify)
ding h. Affer funer	io l	1 Naturai 5 ☐ Pending	(Month, E		Injury	Wo	rk?]Yes 2 □No	Zou. Describe	now injury or	ccurred	
Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of I	njury - At ho	me, farm, st	reet, factory, office		28f. Location (Street and N	lumber or Rui	ral Route Number,
after after I Dire	Certification: To	4 ☐ Homicide determined	building,	etc.*(Specify	v) .			City or To			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the			hysician: To the bes miner: On the basis								
the H nin 24 the Fi	Medical	one)	and manner	stated.	tion and/or i			uned at the time,			
So a with	2	29b. Signature and title of certifier	A 4			29c. Licen			29d. Date s	igned (Month	, vay, Year)
		Wilver	S WO				051610		4/	-24/00	7
B 5		30. Name and address of person who	Completed cause of	death (Item	23a) (Type,	Print)	2170	2			
Stat	e.	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture ,		L(10	64-			
Registra		APR 28 20	109 Cana	ر ساس	ture	GIKA					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

KB

Division of Vital Records. P.O. Box 68760.

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Z Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 11:30 April 25, 2009 **Physician** Patricia Ann Ridoway /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Sandy Spring Friends Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5 Social Security Number Days Hours Months **Funeral** 1 □ M 2 🕏 F Yrs Dec 30, 74 213-32-1806 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State 1 ☐ Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijuy or other traumatic event, it. Madical Extra natural to a once. Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20853 4732 Powder House Drive 14. Race - American Indian, Black, White, etc. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status 1 ∐Yes 2 Ž If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □Yes 2XNo Specify White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Sr. Social Insurance Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Aileen Davis Charles Everett Ridgway, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4732 Powder House Drive, Rockville, MD 20853 Charles E. Ridgway, III /Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD April 30, 2009 Cedar Hill Cemetery 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd W, Silver Spring, MD 20901 The Approximate Interval Between Onset and Death 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the fit failure. List only one cause on each line. Immediate Cause (Final 5 years **Physician** Parkinson's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) inding physician ause as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Year 3 Fctopic pregnancy Month Day atter in the past 12 months? 5 ☐ Other (specify) ned by the a Yes 2 No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No peen 24a. Was an autopsy performed? Yes 2XNo has page 2 1 ∐ Yes certificate 26. Place of Death (Check only one) or Attending Physiclan: 25. Was case referred to medical director, Be examiner? Other: 4 W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2√ No Certification: To this nours after death.

neral Director: After this y filled in by the funeral di 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Injury 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospital within 24 hours a 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 27, 2009 D0035045 30. Name and address of pers in who completed cause of control (Type, Print) Philip G. Henjum, MD 18109 Prince Philip Dr, #200, Olney, MD 2832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 25, 2009 2:30 A Robbins John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Pineview Nursing & Rehab. Center Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1918 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 XXM 2□ F Months Days Hours Min. North Carolina 260-36-1792 91 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event mental by confined once. 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2XX No Directo Prince George's Temple Hills Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 3809 Gull Road 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 凶Yes 2 □ No 19 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1939 1 ☐ Never Married 2 ☐ Married 2 1 ☐ Yes 2 TNo Specify. 1944 Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Conductor Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robbins Virginia C. Thornell Dennis S. မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1907 Sherwood Hall Lane Alexandria, Virginia Priscilla Harris / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 1, 2009 Ft. Lincoln Cemetery Brentwood, Maryland 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause of the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final CONGESTIVE HEART FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi HYPERTENSION resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 2XXNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2XXXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760, Division of Vital Records, or Attending death. within 24 hours after death To the Funeral Director: the

P

altimore, Maryland 21215-0036

State Registrar

APR 2 9 2009

Bahram Pishdad MD

29b. Signature and title of certifier

1328 Southern Avenue S.E. 32. Registrar's Sinature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

#310 Washington, D.C.

D51520

29d. Date signed (Month, Day, Year)

04/28/2009

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Physic		1. Decedent's Name (First, Middle, Last) Howard Eugene R	oss				2. Date of Death Month		3. Time of Death			
/Medi Exami		4a. Facility Name (If not institution, give street an		10		Location of Death		4c. County of E				
Funeral Director		5. Social Security Number 6. Sex 1206-16-8983		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/08/19	Year)	Birthplace (State or Foreign Country) Lorida			
yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits			
r 28a-f s	Director	MD Somerset 10e. Street and Number	Pr	incess	Anne 10f. Zip Code		10	ng. Citizen of Wha	1 X Yes 2 □ No t Country?			
ath with	raf D	30304 Deal Island Ro			2185			USA				
72 hours after death with the Maryland 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examination in the profiled at	by Funeral	1 Never Married 2 Married 1 If Yes	Decedent Ever in U. d Forces? ∕es 2		Vas Decedent of H fYes, specify Cuba □ □ Yes 2 ▼No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Hace - / Black, V Specify:	American Indian, Vhite, etc. White			
paritimity is wary justifual Inc. 15-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination Leads of the date of the date of the date.	Completed	15. Decedent's Education (Specify only highest grade comple		(Give life. L	OO NOT use retired	luring most of work		16b. Kind of Busin	ess/Industry			
filed wi	Be Cor	12 none 17. Father's Name (First, Middle, Last)		Car	penter	18. Mother's Name	e (First, Middle, M		provement			
yid be Mental arked of attic ev	To B	Eugene Preston Ross				Florence	Schaeff	er				
, INGI		19a. Informant's Name/Relationship (Type. Print Audrey French Ross/wi				and Number or Rur 1and Road			te, Zip Code) , MD 21853			
ages 1 a ant of He tr. If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 1	rom State		sition (Name of natory or other plac			20c. Location - City				
Dattillor permit. Pages Department of Important: If it any Injury or o	(4 Donation 5 Other (Specify) 21 Signatur Fundary Ce Licensee 3a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause		22	d Cemeter Name and Addres Inman Fun	s of Facility_			Anne, Maryland			
Physician iticate be executed it by hysician and it	disease or condition resulting in death) a. At A D D M Y O L Y S S Due to (or as a consequence of):											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Med	in the past 12 months?	s, outcome of pregna Live birth 2□ Fetal Pregnant at time of d Unknown	Ideath 3□	Ectopic pregnance Other (specify)	,		23d. Date o Month	f delivery Day Year			
v requires that been signed t	by P	Part II. Other significant conditions contributing	to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye		te to the cause of death? Probably 4 Unknown			
The law recate has bee page 2 shoo	Completed	ALZHEIMER S	0 i-men	TTH			24a. Was an autopsy perform	prio ned? dea	e autopsy findings available r to completion of cause of th? Yes 2 □ No			
sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Mo Hospital:	152 mariant 0 1	ER/Outseties	• 3□ DOA Othe	26. Place of Deat			20(1)			
anding Phy ath. r: After this	ation: To	27. Manne of Death 28a. I	1.☑Inpatient 2 ☐ Date of Injury Month, Day, Year)	28b. Time of Injury	28c. Injury Work	y at	28d. Describe ho	nce 6 ☐ Other (w injury occurred	<i>Бресіту)</i>			
ital or Atterns after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. F	Place of Injury - At ho puilding, etc. (Specifi	ome, farm, stre	eet, factory, office		28f. Location (Str City or Town,	reet and Number o , State)	or Rural Route Number,			
ne Hospi n 24 hou ne Funer oletely fill	Medical	29a. Certifier 1 Certifying Physician: 7 2 Medical Examiner: On and										
To th Withii To th	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (A				
		30. Name and address of person who completed	cause of death (Item	n 23a) (Type, I	Print)	C	/	A CAN	27, 2009			
St: Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 9 2009	32. Registrar's Signa	ture 1.	bare	>/ Net	7 141/2		SAUN + MOZ1834			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amended item For #19b, per f.home, 5/1/09, E.T

Amended item Registrar #8, perF. Home, 4/28/09, BA

Certificate of Death World 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** Emilie Strait 1800 26, 2009 Hori /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death lisbun If Under 24 Hrs Salisburg Rebabilitation & Nursing Cto
5. Social Security Number 6. Sex 7. Age (In yrs. last binkhday) Wicomico Sa Birthplace (State or Foreign Country) Age (In yrs. last binhday 88 Yrs. 8.3/16/1921 **Funeral** Months Days 1 □ M 2 🔀 F 177-28-7836 3/16/2009 Czechoslovakia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕱 No Director MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49 Moonraker Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na. any Injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Unknown Topperzer Maria Franz 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code)

74 Teal Circle Berlin, MD 21811

74 Teal Circle, Berlin, MD 21811 19a. Informant's Name/Relationship (Type. Print) Berthold Strait / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 4/28/2009 Frankford, DE 21. Signature Funeral Service Licensee 22. Name and Address of Facility Burbage Berlin, 108 William St., Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death shock, or heart failure. List only one caus. Steach line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due for as a consequence Examiner Sequentially list conditions, and a line to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 → No 3 Probably 4 Unknown 1 ☐ Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mó 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manager stated. (Check only one) 29b. Signature and title of ca 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAY William H. Robins M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 28 Registrar

Amend #5,5/9, per FD, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. CCHD, 5/6/09, drw State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 9:14 ам Robert Bernard Scheel Jr. 04/27/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4006 Aqua Court Calvert Dunkirk | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1**∑**M 2□F 753-64-5383 Usual Residence of Decedent 60 06/24/1948 Washington DC Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No the Medical Exercitor cost be notified Funeral Director MD Calvert Dunkirk 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 4006 Aqua Court 20754 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Most. Elementary/Secondary (0-12) College (1-4or 5+) Retail Service Coffee Machine Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert B. Scheel Sr. Marian Harcum ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4006 Aqua Court Dunkirk MD 20754 Linda E. Howell-Scheel (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May $\mathbf{1}^{\mathsf{Date}}$ 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Lee Crematory 2009 Clinton. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert P.A. 8125 Southern Maryland Blvd. Owings, MD 20736 21. Signature of Funeral Service Licenses MO1464 John F. Holmes 23a. B. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cronas Hospital or Attending Physician; The law requires that the death certificate be 24 hours after death. Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en performe 2)X No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) den Dr. David Tardio, M.D. 110 Hospital Drive Prince Frederick MD 20678 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

certificate be executed Records, P.O. Box 68760, Division or Vital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir

Baltimore, Maryland 21215-0036

Medical

Certification:

4 ☐ Homicide

29a, Certifier

5

29b. Signature and title certifier achder-5 MD

Year)

29c. License number D0023322

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

126 A E High St, E-ehten MD 21921.

State Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year

Months

7. Age (In yrs. last birthday)

10c. City, Town or Location

66

4b. City, Town, or Location of Death

Bultimore

Physician /Medical Examiner

Funeral

Director ed other than "natural", or items 23a or 28a-f show event, "to account a superior results and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se

death with the Maryland Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10439 ABERDEEN LANE 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 es 2 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: 2 3 Widowed 4 Divorced Year or Dates: 1965-1980 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 CHIEF EXECUTIVE OFFICER n and Mental Hygie is marked other t 17. Father's Name (First, Middle, Last) Be ould be f MARY A. UHAS JOHN SIEDLARZ ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 1 and 2 : Health a PAULA SIEDLARZ WIFE 10439 ABERDEEN LANE EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 8urial 2 ☐ Cremation 3 ☐ R 3 Removal from State OXFORD CEMETERY 4-28-2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit FELLOWS HARRISON ST. JOHN R. MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** int len acous Disseminated Cagulation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last aorne Examine law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Completed peen 24a. Was an has page 2 s Physician: The certificate 1 □ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending injury n 24 hours after death.

Ie Funeral Director: A pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number m, p 941476435N188+3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+VA Faye He Street, Apt. 1410 Balhmere NOWAK 31. Date filed (Month, D State

Siedlarz

1**XX**M 2□ F

Unintersity of Maryland Medical Center

4a. Facility Name (If not institution, give street and number)

10h. County

NOOL

5. Social Security Number

10a. State

145-32-9916

Usual Residence of Decedent

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) AUG 29, 1942 PA 10d. Inside City Limits 1 □Yes 🛣 No 10g. Citizen of What Country? USA 14 Bace - American Indian. Specify: WHITE 16b. Kind of Business/Industry SECURITIES 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State OXFORD, MD HOME, P.A. Approximate Interval Between Onset and Death manth 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

12/14

P 005

4c. County of Death

April

AM

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State #11, FH, TCHD, 4/29/09, rk AMENDED. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month John Rudolph Sewell 04-22-2009 2030 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Hospital Elkton Union 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days Min Hours Vrs 12-08-1953 Maryland Director 55 217-64-0733 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination at the rectified at Director 1 Yes 2 □ No Md. Cecilton Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 'nent of Health and Mental Hygiene. 412 Douglass Ave. 21913 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married - 2 M Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>م</u> Specify: Black 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Standard permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than amy rigury or other traumatic event, the Ms once. Elementary/Secondary (0-12) College (1-4or 5+) Distributor 12 Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blake ဂ Walter Wilson Mariorie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglass Ave., P.O. Box 412, Cecilton, Md. 21913 Hester Sewell / Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Concord Cemetery 05-02-09 Concord, Maryland 31 Signature of Euneral Sonice Licensee 22. Name and Address of Facility Bennie Smith Funeral Home Rd.298, Chestertown, Md.21620 TRYMO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hyperten Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran mell Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown à signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has by page 2 s autopsy performe certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 □ Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 / Impatient Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation ع hours after dea.. جal Director: Afte الاست 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the within 2 To the I 29b. Signature and title of certifier 29c. License number ည 29d. Date signed (Month, Day, Year) DO 4823 Fur cec ids TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 mai et. Elicher Md 21921 223 NEH HHO Went 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 27 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:00 P M Apri1 24 2009 Goldie Irene Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Bridge Frederick 12509 Liberty Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours Min 1 □ M 2 🛭 F Maryland Nov. 4, 1947 Director 219-46-0807 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modical Evandar, out to notified at 1 ☐ Yes 2 No Director Frederick Union Bridge Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21791 United States 12509 Liberty Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∐Yes 2 ⅓ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 12 should be filed w h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Goldie Poole Milburn William Mock ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 12509 Liberty Road Union Bridge, Maryland 21791 John F. Smith, Jr./ Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 Cremation 3 Removal from State 29, 2009 4 □ Donation 5 □ Other (Specify) Resthaven Mem Gardens Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signatur of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Yes 2 No 9 □ Unknown Year in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 3 ☐ Probably 4 ☐ Unknown 2**X** No 1 🗌 Yes certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify)
Injury_at 28d. Describe how injury occurred Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After t 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director; A pletely filled in by the fu 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu April 27, 2009

KB State

State Registrar 31. Date filed (Month, Day, Year)
APR 28 2009

shah

homas bhoson
32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shown Dr Frederick, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** April Tolley Spicer 2009 Rebecca /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cambridge Dorchester General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea Apri. 24, 5. Social Security Number 7. Age (In yrs. last birthday) 1^{Year)}1928 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 217 F Maryland 80 215-26-4323 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Heath and Mental Hygiene. Heath and Marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Cambridge MD Dorchester 1 ☐Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21613 **USA** 104 Richlin Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 Sif Yes, Give Year or Dates: 1 Never Married 2 Married 2 7 No 1 ☐ Yes 2 🔼 No white Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator restaurant 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Andrew Tolley Flora Booze ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Davis 5652 Beach Haven Road, East New Market, MD 21631 daughter permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/09 Church Creek, MD Old Trinity Churchyard 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Thomas Funeral Home P.A. 5-14 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Anoxic **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of): Fibrillaha with- cordize owen Examiner Ventrical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Cordividuler dilecte Examir ATTERIOSCIENTAL attending physician and for use as the burial-trar Due to (or es e consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Ceath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Box 68760, P.O. Records, of Vital Physician: Division Hospital or Attending

Baltimore, Maryland 21215-0036

24 hours after death Funeral Director: filled in by

within 2 State

Certification: To Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) end manner stated. 29c. License number 29b. Signature and title of certified

D 47924

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST CAMBRIDGE MD 21613 503 BYRN TIMANWY MOMAN

32. Registrar's Signature 31. Date filed (Month, Day, Year)

APR 27 2009

Registrar

amend line 23a-a perPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. phy, aaco hith dept 4/28/08 tate of Maryland / Department of Health and Mental Hygiene Reg. No. 4 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Robert Germain Scharf 10:30pm M 4/18/2009 /Medical 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/28/1925 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 5 M 2 □ F Ν̈́Υ 83 Director 522-30-7604 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2√No Director Anne Arundel MD Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 930 Bay Forest Apt. 304 21403 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event and once." Elementary/Secondary (0-12) College (1-4or 5+) Sales Yacht Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Scharf Dorothy Germain ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Scharf Daughter 765 Whitneys Landing RD. Crownsville,MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/21/2009 | Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. -{ 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Post Obstructive Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions Examiner cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 📝 🛪 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41816 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 135 Old Solumens Island RD, Annapolis MO ha! 31. Date filed (Month, Day, Year) Registrar's Signat **APR 28** Registrar

amend #17618 Per Inf G891 5/18/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2009 Year April 9:30A. 22, Ruth Richards Seger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Hospital Laurel Prince George's Months Days Hours Min. September 19916 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 578-09-1544 1 □ M 2 □ F 92 Maryland Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f sho the Medical Examinat must be notified at Maryland Prince George's Beltsville 1 □ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 20705 6504 Muirkirk Road United States Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status 14. Race - American Indian. 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: ģ White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home h and Mental Hygie 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be Scorge Lewis -Richards G.Edward Richards Esther -Gemeny Ester Gemeny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Barbara A. Lammers -daughter 11703 Laurel Bowie Road Laurel, Maryland 20708 20a. Method of Disposition
1

ABurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Maryland Veterans Cemetery 4/29/2009 Cheltenham,Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio-Pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Upper Gastro-Intestinal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached f 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Urosepsis; Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 2X No 1 ☐ Yes 2 **X**No 1 ☐ Yes After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 DXNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending ours after death.
neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60936 April 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul Tak, M.D. LRH 7300 Van Dusen Road Laurel, Maryland 20707 egistrar's Signature 31. Date filed (Mon-State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Queen Ann Simmons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ADEL LAND Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Country) **Funeral** Days Min Day, Year Months 6/11 Hours 1 □ M 2 🗙 F Director Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Ex-miner must be notified at 1 X Yes 2 □ No Director DC None Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4522 15th St. NW 20011 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or iten 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 🖾 No Saltimore, Maryland 21215-0036 Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DC Public Schools 5+ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Simmons Mary Squire 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. Mildred Moseley/sister 4522 15th St. NW Washington DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 4/30/2009 Brentwood, MD 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses Mershall 4217 9th St. NW Washington DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Onespiraton disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed wows @ (20 rosz the burial-trag Box 68760, physician for use as ed by the attending I IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2. No 3 Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an ate has bage 2 s certificate INOSOPS 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No I hours after death. •uneral Director: A death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours at Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

47867

person who completed cause of death (Item 23a) (Type, Print)
NIX-B. 4701 Randolph Rd #216. Rockville MD 20852.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 11:35 P M **Physician** Frank L1ovd Shears, III April 26, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
Under 1 Year | If Under 24 Hrs.
onths Days | Hours | Min. Holy Cross Hospital Montgomery If Under 1 Year Months Days Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**□ M 2 □ F 65 578-58-4102 1943 Director Aug 15, Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Exerciper must be notified at 1 XYes 2 No Montgomery Silver Spring Directo Maryland | 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 13108 Cabinwood Drive United States Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or iten ary or other traumatic event, the Mudical Everina. 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify Specify: Completed by Black 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5^{College (1-4or 5+)} years Contracts Manager Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank L. Shears, Jr. Emeline Banks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13108 Cabinwood Drive Silver Spring, MD 20904 Sheila Shears - Wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of P Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery May 4, 2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Liver 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part is often the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Sacral Decubitus Ulcer Infection burial-trai Due to (or as a consequence of) P.O. Box 68760, ned by the attending physician detached for use as the buris Physician/Medical Parkinson's Disease IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ò Myotonic Dystrophy, Coronary Artery Disease, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Be Completed Hypertension, Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has breaking the rector, page 2 s autopsy performed? 1 □ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ANatural after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4/27/2009

10 State Registrar 30. Name and ad ress of pe on who completed cause of death (Item 23a) (Type, Print)

Dr. Candice Wilson 1500 Forest Glen 1500 Forest Glen Road Silver Spring, MD 20701 32. Registraris Signature te filed (Month, Day, Year APR 2 9 2009

D67901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 2009 10:10P M Anthony L. Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice N/A Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 14 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1972 1**⊠** M 2□ F Days Hours Min. Country) Naryland Months 220-84-1924 36 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State 12 should be filed within 72 hours after death with the Mary th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, it a Modical Examinar to an united. MarylandPrince George's 1 ☐ Yes 2 🛛 No Laurel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3504 Spring Rd. 20724 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. rmed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. δ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th 0 Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur W. Thomas ဂ Helen Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,0\,6\,1$ Pages 1 and 2 sl ment of Health an item 2 Laticia Bennett(Friend) <u> 7994 Silent Winds Ct. Apt B Glen Burnie, </u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State April 30 OLaurel, Md. Mt. Zion Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Miniame Receive of &ciliSons Mortuary, P.A. 821 West St. Annapolis, Md. arry J. Beese MODY 83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons vuence of): Examiner Sayumtian, list a children if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-tran resulting in death) Last Due to (or as a consequence of) that the death certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No detached O. 9 Unknown 9 Unknown ģ ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an The certificate 1 □ Yes 2 No Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 3 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) ð 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No Certificati 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a Funeral C 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ess of pe State Registrar

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MODITA, HAY TRAN

09-03307 Virginia Zamaken	_	Please Type or Print in Black Indelib State of Maryland / Departme								
Van Akeı Physician	_		e of Death	Reg.	No. 2009 15379					
Medical Examin	er	Virginia Ann Van Aken		Month E April 24, 200	Day Year 2036 hrs					
		4a. Facility Name (if not institution, give street and number) Montgomery General Hospital	4b. City, Town, or Location Olney	of Death	4c. County of Death Montgomery					
Funeral Director		5. Social Security Number 051-74-7318 051-74-7318 051-74-7318 051-74-7318 051-74-7318 051-74-7318 051-74-7318 051-74-7318	ay) If Under 1 Year If Under 1 Year Months Days Hour		(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) New York					
rland -f show any once.		10a. State 10b. County 10c. City, Town or New York Greene Henson	nville		10d. Inside City Limits 1 Yes 2 X No					
the Mary	Dire	10e. Street and Number 54 Goshen Road	10f. Zip Code 124		Citizen of What Country? United States					
5 2 E	Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 Yes 2 No specify No specify	n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
6 172 hours a aan "natura cal Exemin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	cedent's Usual Dccupation (Give ring most of working life. DO NO		6b. Kind of Business/Industry Nursery					
5-0036 iled within 77 Hygiene. I other than the Medical	Ĕ.	12 0 17. Father's Name (First, Middle, Last)	Secretary 18.Mothe	r's Name (First, Middle, Ma						
1215 I be file ental Hy irked o	8	Douglas Henry Van Aken	Pa	tricia Ann	Hug					
MD 21 nd 2 should 1 th and Mer m 27 is man aumatic ev	의		Mailing Address (Street and Nu 5608 Coltrane D		er, City or Town, State, Zip Code) us, Md. 20872					
Ore, I			Disposition (Name of cemetery, or other place)		20c. Location - City or Town, State					
Baltimore, permit Pages I an Department of He Importanti: If ite	ŀ	4 Donation 5 Other Specify: Metro 21. Signature of Funeral Service Licensee	oolitan Crem. 22. Name and Address of Facili	4/28/09 ty	Alexandria, Virginia					
	_	Glog w. Barlon	Muriel H. Bar P. O. Box 50	38. tavtonsv	ille. Md 20882					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac tamponade Due to (or as a consequence of):	enter the mode of dying, such as	cardiac or respiratory arrest	t, shock, or heart Approximate Interval Between Onset and Death					
		Sequentially list conditions,	eurysm							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Clisease or injury that initiated								
xecuted n and - transit		events resulting in death) Last Due to (or as a consequence of):								
० ल ल	gical	UNPENDED X AMENDED #1 as noted	per ME g891 5/	22/09 TT						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transfer.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify) Unknown								
F.O. ires that the signed by t	S S	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in P		acco use contribute to the cause of death? 2 ✔ No 3 Probably 4 Unknown					
tal Records, cian: The law require certificate has been sigector, page 2 should by	Completed			24a. Was an autopsy perform	ed? death?					
Vital Recysician: The his certificate director, page	e Re	25. Was case referred to medical examiner?	26.Place of Death		F 1.					
ing Physic	의	1 ✓ Yes 2 No Timpatient 2 ✓ Erodup 27. Manner of Death 28a. Date of Injury (Month Pay Year)	ne of Injury 28c. Injury at Wor		w injury occurred					
Sion Attendin death. ctor: A	ertification:	Pending 2 Accident Investigation	1 Yes 2							
Division spiral or Attent ours after death reral Director: filled in by the		3 Suicide 6 Could not be determined (Specify)	n, street, factory, office building, e	etc. 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location (Structure) 28f. Location	eet and Number or Rural Route Number, City te)					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	<u> </u>	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death and manner stated.								
H × H V	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)					
4	-	Allen Stravell, MO 30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		April 25, 2009 					
KB		Melissa Brassell, MD Assistant Medical Examiner 1	11 Penn Street, Baltimpi	re, MD 21201	, 1 ₂ -1 ₂					
Sta Registra	~	31. Date filed (Month, Day, Year) APR 2 8 2005 32. Registrar's Signature	arked							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 2009 28 John /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 1 Year | If Under 24 Hrs. MM 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 □ F 48 216-78-3235 Director 24,1961 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipartment of Health and Mental Hyglene. In item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 □Yes 2 No Funeral Director Maryland Washington County Clear Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13355 Independence Rd. 21722 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced Ī 983 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working
lite. DO NOT use retired)

Mechanical Engineer
Technician Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John L. Worthington, JR. Alice V. King Worthington P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13355 Independence Rd. Clear Spring, MD 21722 Linda A. Worthington-wife 20b. Place of Disposition (Name of cemetery, crematory or other place).
Broadfording Church 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-2-2009 Hagerstown, Maryland 4 Donation 5 Dother (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complicant as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) eucepha /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of I or Attending Physician: The law requires that the death certificate be executed after death. Non-ischemi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Tes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □ Yes 2 3 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 thipatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 No 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D68107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOH 23+1 State

31. Date filed (Month, Day,

Mer

32. Registrar's Signature

MAY 0 1 2009

Registrar

Green S+ Baltmare, m)

		Please	Type or Prin						_	jible.	
		For State Registrar	State of Ma	aryiand / i	•	artment of F rtificate of L		-	gierie Reg. No.	119	15381
		Decedent's Name (First, Middle, La	ıst)	0				2. Date of De		کستانیات د	3. Time of Death
Physicia /Medic		PHYLLIS	ANN	WOOD				Month APRIL	27 2	Year 2009	7:13A M
Examin		4a. Facility Name (If not institution, given	ve street and number)			4b. City, Town, or	Location of Death		4c. Coun	ty of Dea	th
		FREDERICK MEMORI				FREDERIC				ERIC	
Funeral		Social Security Number 6. S	Sex 7. Ag 1 □ M 2 🖾 F	e (In yrs. last bii		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	C	thplace (State or Foreign
Director		131-20-8003	10 W 2 W 1	80	Yrs.			Jan. 20	6, 1929	N	ew´York
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
Maryi f shc	ō	New York Oueens		Вау	cida	3					1X Yes 2 No
the 1	Director	10e. Street and Number		Day	3 T U V	10f. Zip Code			10g. Citizen o	f What Co	ountry?
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death ms 2	Funeral	11. Marital Status	12. Was Decedent I		13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No)- 14. R		erican Indian,
after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	No		ir Yes, specify Cuba 1 ∐Yes 2⊠ No	Specify:	nican, etc.)		ack, Whit	e, etc. White
ours ral",	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:			10163 220110	Opcony.		Spec		
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within 72 ho giene. r than "natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		D <i>O NOT u</i> se <i>retired</i> nemaker	1)			Own 1	Home
If E. 12. 13. 10. 10. 10. If the Maryland filled within 72 hours after death with the Maryland Hygiene. Hygiene. The Maryland Franking or 188-f. show ant, the Markeal Examination rust be neithfied at		17. Father's Name (First, Middle, Lasi	*)		1101	Helliakei	18. Mother's Nam	e (First, Middle			Home
d be i	Be C	Anthony DeVasto	•					McAllis		,	
should Me Mark	잍	19a. Informant's Name/Relationship		198	. Mailin	ng Address (Street				n, State,	Zip Code)
nd 2 salth a		Thomas P. Kelly		43	329	Bartholov	s Road	Mt. Air	y, Mary	land	21771
s 1 a		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of natory or other place		Date ri1	20c. Location	n - City or	Town, State
Page nent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				Memorial		2009	Farmin	igda1	e, New York
permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Important: if Item 27 is marked other than "n any Injury or other traumatic event, the Medicone.		21. Signature of Funeral Service Lice	nsee		22	2. Name and Addres	ss of Facility	Stauffer	r Funer	al H	omes, P.A.
88188		W. C. Q. J. to			16	21 Oposs	umtown Pi	ke Fre	derick	, Mar	yland 21702
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	ne.			A /	_	- *		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final diseese or condition resulting in death)	a. Chive	onicu	ונחי	metive	/ W/ mor	Tary 1	Sisean	C	Yenns
/Medical Examiner			Due to (or	a consequence		ia					DAYS
ਰ ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A 1	e consequence	of):	Heart	C. 1.	<i>.</i>			DAYS.
executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	gertiv		Tearl	Tacing	e			Dr. 73 .
eath certificate be executed attending physician and for use as the burial-transit	-	lesdring in death) Last	Due to (or/a)	a consequence	OT):						
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certif nding ise as	//Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d [Date of de	livery
leath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No		2 Fetal death		☐ Ectopic pregnanc ☐ Other (specify) _	у		1	Month	Day Year
The law requires that the death certificate are has been signed by the attending phys bage 2 should be detached for use as the l	Physician/Medica	9 Unknown	9 □ Unknown								
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ician: The certificate ector, pag	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only			
hysl this c	ဥ	1 Yes 2 No		ent 2 ER/O			4 LI Nursing n	ome 5 Resi			ecify)
ling F	ioi:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ay, Year)	Time of Injury	Worl	yat k? Yes 2 □No	28d. Describe	now injury occ	urred	
Attending Physician: r death. ector: After this certifica by the funeral director, p	icat	2 Accident investigation 3 Suicide 6 Could not be	e Place of Inju	iury - At home fa	arm str	eet, factory, office	res 2 🗆 No	28f Location /	Street and Nu	mber or F	Tural Route Number,
after Dire d in b	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)		, , , , , , , , , , , , , , , , , , ,		City or To	wn, State)		
sspita hours ineral y filler	alC	29a. Certifier 1 Certifying P	hysician: To the best	of my knowledg	e, deat	h occurred at the ti	me, date and place	, and due to the	cause(s) and	manner a	as stated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	(Check only 2 Medical Exa	miner: On the basis of and manner sta		ng/or in	vestigation, in my c	opinion, d eath occu	rred at the time,	·		
To t Com	Σ	29b. Signature and title of certifier	12-			29c. Licens			29d. Date sign	ned (Mon	th, Day, Year)
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12		30. Name and eddress of person who					D4 #	ეე∩ 17	a d a sad a 1.	. M	ruland 21702
Sta	to	Praveen K. Bola 31. Date filed (Month, Day, Year)		196 Th			ı Drive #	ZOU FT	ederick	, ma	ryland 21702
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 28 2009

09-03279

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Thomas White Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 23, 2009 1926 hrs THOMAS ALLEN WHITE Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles Indian Head 4310 Indian Head Hwy, Apartment #6 g. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Country) Months Days Hours April 18, Maryland 1 X M 2 F Director 215-46-3844 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 1 Yes 2 X No Charles Indian Head other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Maryland Baltimore, MD 21215-0036
pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20640 U.S.A. 4310 Indian Head Highway #6 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes White Specify: Yes 2 X No specify: 4 X Divorced f Yes. Give Yea Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) Construction Steamfitter 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Martha B. Mitchell Clarence E. White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13730 Hillside Avenue, Thurmont, MD 21788 Clarence E. White, Jr. Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition

1 Burial 2 X Cremation crematory or other place) Removal from State 4/28/09 Smithsburg, Maryland Smithsburg Crematory Donation 5 Other 22. Name and Address of Facility
ROBERT E. DAILEY & SON FUNERAL
615 EAST MAIN STREET, THURMONT natus Furteral S Approximate Interval d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 23a. Part K Enter the dis-Between Onset and Physician failure. List only one cause on Death Medical Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed X AMENDED PII per ME G891 5/26/09 TT Physician/Medical UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. Yes 2 No 3 ✔ Probably 4 Unknown þ Chronic alcohol abuse Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? has 1 V Yes Yes 2 certificate 26 Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Be Residence 6 V Other: Scene examiner? Hospital: 1 DOA Nursing Home 5 Inpatient 2 FR/Outpatient 3 After this 1 V Yes ٩ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending within 24 hours after death To the Funeral Director: Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 24, 2009 O.C.M.E. 30. Name and address o person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Registrar's Signatur 31. Date filed (Month, Day, Year, arka

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

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State Registrar DHMH 17 Rev 1/2001 2835

30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

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SMITH CIVE, SUITE 203

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21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** \mathbf{p}^{M} Amelia Jean Wirth 1:50 April 26. 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2XXF Months Days Hours 94 216-92-4803 Director July 12, 1914 OH Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show 10a. State ms 23a or 28a-f shor Director 1 ☐Yes 21 No MD Montgomery Silver Spring with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Hilltop Road 20910 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō 1 ☐Yes 21 No Specify. Specify: White ⋛ 3 ₩ Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Department of Health and Mertal Hygic Important: If item 27 is marked other any in ury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Michael Wilks ္ရ Alexandra Wanda Bondeska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Wirth /Son 4709 Hornbeam Drive, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 Removal from State Metropolitan Crematory April 28, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of FacilityFrancis J. Collins Funeral Home Inc. ewlllamsu 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Bowel Infarction 36 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lissass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 2**X** No ned by the a signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 🌠 No 3 ☐ Probably 4 ☐ Unknown Arteriosclerotic Heart Disease icate has been si Completed Chronic Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Chronic Bronchiectasis 1 ☐ Yes 2 🛛 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide

that the death certificate be executed Box 68760 P.0. Division of Vital Records, law requires al or Attending F after death. I Director: After 24 hours a Hospital

Maryland 21215-0036

Baltimore,

State

completely

To the within 2

Medical

4 Homicide

(Check only one)

George

29b. Signature and title of certifier

29a. Certifier

Registrar DHMH 17 Rev 1/2001 1500 Forest Glen Rd, Silver Spring, MD 20910

1 detail Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0012121

28f. Location (Street and Number or Rural Route Number, City or Town, State)

April 26, 2009

29d. Date signed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Fagistrar's Signature

neur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For		State of Ma	•	epartment of l		, ,	0.0	100	1 = 0 0 =	
			1 - State Registrar				Certificate of	Death		Reg. No. 2	109	15385	
	Physici /Medic		1. Decedent's Name (Bett	y Lee	Wissman				2. Date of Dea April	24, Day 200	9 ^{Year}	3. Time of Death 5:15P M	
	Examir	ier	4a. Facility Name (If n	_				r Location of Death larlboro		4c. County			
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920	72 hours after death with the Maryland "natural", or items 23a or 28a-f show adhal Even in the notified at	by Funeral	11. Marital Status1 ☐ Never Married3 ☐ Widowed 4 [12. Was Decedent I Armed Forces? 1 □Yes 2XX If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 □Yes 2 □ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - America k, White, et :: Wh		
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ylar	e c t p	To E		Glenn R.				Annie	e Lucill	e Jame	:S		
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ē,	ges 1 and 2 t of Health a if item 27 is or other tra	H	20a. Method of Dispos		WISSIIGH		303 Goldenro Disposition (Name of y, crematory or other place			20c. Location -			
E O			1 XX Burial 2 □ 6 4 □ Donation 5		Removal from State	1	y, crematory or other plac y View Cemet		29,2009		Nokesville, Virginia		
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Fune	eral Service Licer	309		22. Name and Addre	see of Facility	e Funera				
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=	Physician: r this certific ral director, I) Be	25. Was case referred examiner? 1 Yes 2 No		Hospital:		tratiant 3 DOA Oth	26. Place of Deat					
ا م	ding Physician; The I h. After this certificate he funeral director, page	n: To	27. Manner of Death		28a. Date of Inju	ry 28b. T	patient 3 DOA	4 LI Nursing Ho	28d. Describe h	lence 6 ☐ Oth low injury occurr)	
Sior	Attending ir death. ector: After by the funer	catio	2 Accident	5 ☐ Pending investigation 6 ☐ Could not be		, 7641)		Yes 2 □ No					
Division	after d Direct Jin by	Certification: To	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Inju building, etc	rry - At home, far c. (Specify)	m, street, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,	
	lo the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the						, death occurred at the ti						
	o the lawithin 2. To the Complet	Medical	one) 29b. Signature and title		and manner sta	ited.	29c. Licens			29d. Date signe			
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0		ŀ	30. Name and address	s of person who	completed cause of d			1 -		11-4	1	1 1	
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	Sta Registr			PR 282		ar's Signature	parket					0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. / 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year MAGENTA CARNEY YGLESIAS 2009 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT 8. Date of Birth (Month, Day, Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 - M XX NOV. 8, 579-42-5726 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 1 ☐ Yes XXNo OXFORD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21654 USA 27162 OXFORD RD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married Specify: WHITE 1 □Yes XXNo Specify 3 Widowed 4 Nivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INTERIOR DESIGN SELF EMPLOYED 5± 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAUREL WALKER ALLAN A. CARNEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10429 HEADLY CT. FAIRFAX, VA 22032 JOHN YGLESIAS SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4-30-2009 OXFORD, MD OXFORD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 ER JOHP R. MERC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 9 Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 pares 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

items 23a

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is marked other

Director

Funeral

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Completed

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MD

Injury or other traumatic event, the Medical Examiner must be notified at

72 hours after death with the Maryland

I be filed within 7 intal Hygiene.

Pages 1 and 2 s ment of Health ar permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau once.

Baltimore, Maryland 21215-

Examiner

Physician/Medical

2

Completed

Be

Certification: To

cal

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar the page 2 should certificate this After 1 death. hin 24 hours after deat the Funeral Director: filled in by

Division of Vital Records, P.O. Box 68760,

IDPX

Hospital

Registrar

30. Name and address of person who completed caus of death (Item 233) (Type, Print)

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

Injury at Work?

1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

31546

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2195. Washington St. Easton, Mo 216

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2^{Day} , SSU-PING APRIL 2009 2230 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital MONTGOMERY Rockville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) Jan. 5, 1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Country) China 1 □ M 217 F Director 220-08-4456 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Madical Examiner must be notified. 1 □Yes 🏖 No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14711 Softwind Drive 20878 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√∑No Specify Chinese 2 Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Home 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kung-Jan Chen Shih Huang ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Yu (Daughter) 14711 Softwind Dr, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem Park 4/30/09 Rockville, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, 21. Signature of Funeral Service Licensee 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Acute Respiratory Failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to lor as a consequence of The law requires that the death certificate be executed Disseminated Herpes, Zoster and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) signed by the a □Yes 2 XNo Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Diabetes Mellitus 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □Yes 2 No 2 🗆 No 1 □ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2XXXo this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hou To the Fune completely fi Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14 Can D41162 4/22/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, 19529 Doctors Drive, Germantown, MD 20874 M.D. 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 1000 John Akins 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square Hospital Center Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 2 - 0 3 - 1 9 2 8 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Months 194-20-1371 80 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Nevical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21237 6600 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 14. Race - American Indian,
Black, White, etc.
African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married An Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify ò Specify: American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. NA Black & Decker Unknown Laborer 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\stackrel{ ext{M D}}{2}$ $\stackrel{ ext{1}}{2}$ $\stackrel{ ext{0}}{0}$ 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 and 2 and 2 moratment of Health a Important: If item 27 is any Injury or other trauonce. Artie Shaw-Guardian North Calvert Street Site #220 Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State on Cem. | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Louden | 05-12-200p Loude Mt. Zion Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 638 North Gilmor Street Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Tuberculosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death cert ficate be executed ASPIRATION sician and burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe certificate 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Alex Huang

MAY 1 3 2009

altimore, Maryland 21215-0036

P.O.

Records,

Division of Vital

9000 FRANKLIN Square DR

29c. License number

RES 0000

29d. Date signed (Month, Day, Year) 5-8-2009

Balto md

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-02976 Danielle Astride	1		ease Tyr St	oe or Prin ate of Ma	t in Bl ryland	/ Departr	ment o	nk. En f Health f Death	n and	All Co Menta	ıl Hygie	ne Reg. I		20	09 53
Physicia Medical Examii	ın/ ner	1. Decedent's Nar Daniel	le Ast	ride Av							Ap	ate of Death onth Da oril 14, 200	9	Year	3. Time of Death 1228 hrs
		4a. Facility Name 1500 Fores			nd number)			4b. City, To Silver		cation of i			Mont	gomery	
Funeral Director		5. Social Security None	Number	6. Sex	. `	e (In yrs. last t	birthday) Yr	If Under Months	_	If Under : Hours		Sept. 1		101 Cou	hplace (State or Foreign untry) abon
ow any		Usual Residence 10a. State MD	10b. County	gomery		10c. City, Tov	wn or Loca		lver	Spr	ing				10d. Inside City Limits 1 Yes 2XX No
he Marylanc	Director	10e. Street and N		n Dr.		<u></u>		10f. Zip (2090	2		10g.	Citizen d Gal	of What Cour	ntry?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Disparation of Health and Mental Hygiene. Disparation of the file of the marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner mast be notified at once.	Funeral	11. Marital Status 1 XNever Mar	rried 2 N	Married Arm	ned Forces Yes 2	Ever in U.S.	lf '	as Deceder Yes, specify	Cuban,	Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)	,	White, etc.	can Indian, Black,
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AD 212 2 should be h and Ment 27 is mark	ToE	19a. Informant's Bertran		ship (Type, Prin ne / Fa		14	10907	Pebb	Run	Dr.	, Sil	Route Number	ring	, MD	20910
Baltimore, MD permit. Pages I and 2 sht Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 5/6/2009 Silver										-	ring, MD		
Baltir permit. P Departme Importan		21. Signatur of	Funeral Service	e Licensee		m0073	2 3	Name and Rapp F 933 Gi	uner	al &	Crem Silv	ation S er Spr	Serv:	ices MD	20910 Approximate Interval
Physician 'M dical aminer		Immediate Caus	only one caus e (Final diseas	se on each line. se a. Sud	lden	unexpe						spiratory arres	it, snock,	or neart	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): b. Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):												 	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):													
e executed cian and rial - transit	a	23a 27 parMF g891 5/21/09 TT													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician is completely tilled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	IF FEMALE: 23b. Was deceded past 12 mor	ent pregnant in hths?	the 1	Live birth Pregnant	ome of pregna	2	Fetal death Other (Spe		Ectopic	pregnancy	′		Date of delive onth	ny Day Year
P.O. BC so that the dea gned by the a	by Phys	Part II. Other si		3	Unknown uting to de	ath but not res	sulting in th	e underlyin	g cause (given in Pa	art I.				o the cause of death? obably 4 Unknown
cords, F law requires has been sign	Completed											24a. Was a autops perform	sy med?	24b. Were prior to death?	
al Reom: The crifficate tor, page	e Cor	25. Was case re	eferred to medi						26.Place		(Check on	y one)			
Division of Vital Records, tal or Attending Physician: The law requirant after death. In Director: After this certificate has been seled in by the funeral director, page 2 should!	on: To B	examiner? 1 ✓ Yes 27. Manner of D 1 X Natural			1 Inpa a. Date of I (Month, Da	njury	ER/Outpati 28b. Time			Other ₄ Iry at Work		dome 5 1	Residence low injury		ner:
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director A completely filled in by the Unit	Certification:	2 Acciden 3 Suicide	ft In	ould not be	se. Place o	Injury - At hor	me, farm, s	ne, farm, street, factory, office building, etc. 28f. Location (Street and Number or or Town, State)							Rural Route Number, Cit
the Hospita in 24 hours the Funeral	Medical Ce	4 Homicio 29a. Certifier (Check only one) 2	de Contibular	Physician: To	the best of	xamination an	e, death o	ccurred at th	ne time, d	ate and pl	ace, and du	ue to the caus he time, date :	e(s) and and place	manner as s e, and due to	tated. the cause(s)
To T	Med	and manner stated. 29c. License number 29d. Date signed (Month, April 15, 2009													
d		30. Name and a						11 Penn	Street	Raltim	ore MD	21201			
4	State		Alexander 1 Wonth, Pay Ye		1	dical Exam			Street	, Daillin	UIC, IVID	Z 1ZU I			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12:224 Month **Physician** 2009 MGC. /Medical 4c. County of Death 4a. Facility Name If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year Months Davs If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🔀 F Sept28,1919 Virginia 214-44-2188 89 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County 28a-f show Md. Baltimore City 1X Yes 2 □ No Director other traumatic event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 21231 U.S.A. 513 South Chester Street items 23a by Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify White Specify: 3 ₩ Widowed 4 Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. 7th <u>Home Maker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unk) Jeffries Lawrence Knick ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 513 South Chester St. Shirley Trillos(Daughter) Baltimore, Md.21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 5-15-2009 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilikaczorowski Funeral home, PA 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ion **Physician** Ю /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the at completely filled in by the funeral director, page 2 should be detached formations. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2 🗌 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 1

Inpatient Other: 4 \sum Nursing Home 2 No 2 ER/Outpatient 3 🗆 00A 5 Residence 6 Other (Specify) မ 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day 2 🗌 No 1 Tyes 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

as Khul

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

numinus

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of	Maryland		irtment of H		nd Mental Hyg	') {	200	15391		
			Registrar 1. Decedent's Name (First, Middle,	Last)				Jealii	2. Date of Dea	Reg. No. 🚄 🕻		3. Time of Death		
Е	Physicia		LEOLA			Boo	KER		Month	Day 6	Year	15:32 M		
4	/Medic Examin		4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town, or	Location of D						
1	LAGIIIII		The Johns Hopkins				Baltimore				1 - 5:			
	Funeral		5. Social Security Number 214–24–2710	6. Sex 7. 1 ☐ M 2 💢 F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day	, Year)	9. Birthpi Count	y)		
_	Director	-	Usual Residence of Decedent	71					11-5-19	<u> </u>		VA -		
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	e Mar Ba-f s	Director	M) n/a	1		Balti								
	ith th		10e. Street and Number				10f. Zip-Code					ry?		
	sath w	Funeral	1705 N. Washingt	on Street 12. Was Decede	ent Ever in U.S	3. 13. 1	Vas Decedent of H		n? (Specify Yes or No-			an Indian,		
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93	al", o	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Date	es:									
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Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other	4	21. Sign 1 e of Funeral Service L		1 .	22	2. Name and Addre	ess of Facility	Wylie Funera	1 Hane P	.A. of	Balto. Co.		
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Division	or Attend after death Director: /	ertification:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place o	of injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str y)	reet, factory, office		28f. Location City or Tou	(Street and Nui wn, State)	mber or Run	al Route Number,		
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifyin (check only one) 1 Medical	g Physician: To the base Examiner: On the base and mann	sis of examina	wledge, deat tion and/or ir	h occurred at the ti	ime, date and opinion, deat	place, and due to the h occurred at the time	cause(s) and , date and plac	manner as see, and due	stated. to the cause(s)		
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4	(1 0	S			K2	5-00		May	10,	2009		
_			30. Name and address of person Anthony	sung			, Print)	6	600 North Wo	olfe St, B	altimo	re, MD, 21287		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	bark	les les							

09-02932 Baby Harris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

by Harris		For State	ate of N	Maryla	nd / Depar <i>Cert</i>	rtment of tificate of			Mental	Hygi		Reg. No.	200	9 15	39
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edical Examine		Baby Boy			Baby Bo	y Harri	S b Cit	y, Town, or Lo	cation of De		April 12,		. County of Deat		
	1	4333 Pimlico Road	ii, give sile	et and no	mber,	"		ltimore							
Funeral	5	. Social Security Number	6. Sex	T	7. Age (In yrs. la	st birthday)	-	Inder 1 Year	If Under 24		. Date of B	irth(MM/	/DD/YYYY) 9. Bi Forei	rthplace (State or	
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8	_	Jsual Residence of Decedent 0a. State 10b. County			Inc City	Town or Location	nn -							10d. Inside City	
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the Maryland or 28a-f shiffed at onco		4333 Pimlico Road						2121	5				USA		
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten injury or other transmatic event, the Medical Examiner must	Ī	20a. Method of Disposition 1 Burial 2 Crematic	2 7	Pamoval f		Place of Disposi prematory or oth			etery,		Date	20c	. Location - City of	or Town, State	
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Division of Vital Records, P.O. Box 68766 Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending phy tell principle of the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Certification:	3 Suicide 6 Co	uld not be		ice of Injury - At h	nome, farm, stre	eet, fa	actory, office by	uilding, etc.	. 2	28f. Locatio or Tow	n (Stree n, State)	t and Number or 4333 Pir	Rurat Route Numb	ber, City
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To the He within 24 within 24 complete	Medical	(Check only 1 Certifying one) 2 Medical Ex	aminer: On	the basis	est of my knowled s of examination a	and/or investiga	arrea ation,	in my opinion,	death occi	urred at	the time, d	ate and	place, and due to	the cause(s)	
To with	ğΕ	29b. Signature and title of certi		d manner	stated.			29c. License	e number		<u>.</u>	29	d. Date signed (Month, Day, Year)	
		Carol	HA	ce C	din			0.C.I	M.E.			A	pril 13, 2009		
_	1	30. Name and address of pers				m 23a)	_	- 1 D III		04004					
					I Examiner Registrar's Signat	111 Penn	_	7.001757	ore, MD :	Z 1201			-		
Sta Registr	×	31. Date filed (Month, Day, Yea	3 208	9 2	Parents Signal	B. 400	w								

DHMH 17 Rev 1/2001 OCME 2006

OCME

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State of Maryland / Department of Health and Mental Hygien@ Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician 10:45 PM M 2009 Frederick R. Burger
4a. Facility Name (If not institution, give street and number) /Medical May. 6, 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges County Medical Center Hyattsville Prince Georges If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1⊠M 2□F Yrs. Director (Unknown) 69 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 N Yes 2 No Direct MD Montgomery Takoma Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 434 Ethan Allen Blvd.

11 Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

→ □ ✓ △ □ ☑ No Funeral United States 20912-13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Automotive Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 99 and Mental Margaret Pope Maultram Balls Burger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth (item 27 i 7304 Connecticut Ave. Chevy Chase, MD 20815-Lorraine Nucci/Daughter Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 = 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department Important: If any injury or once. May 11 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility 2009 21. Signature of Funeral-Service bice m0382 Rapp Funeral & Cremation Services tiched to 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx. Silver Spring, Maryland 20910—
Approx. Silver Spring, Maryland 20910—
Approx. Silver Spring (Maryland Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial **Physician** intarction disease or condition resulting in death) 40-15 /Medical Due to (or as a consequence of) Examiner androvosadar Arterioscherot Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of t Due to (or as a consequence ot). Examine The law requires that the death certificate be executed inding physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical ettending I for use as IF FEMALE 23c. If yes, outcome ot pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the end be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ئە Part HnOther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 □Unknown Should 1 ☐ Yes 2 ☐ No been 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No nts later 24a. Was an page 2 s hes certificete 2 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1- Natural 5 Pending within 24 hours efter death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DO1852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 4203 Queensbury Rd Muatts ville MD 2024) V 31. Date tiled (Month, Da Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Clare May 8, 2009 12:20p M Dorothy Beer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 18, 1920 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1 M 2 J F 220-01-2108 88 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Harford Fallston Md. 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 403 Merrie Lane 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 M If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 ₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora M. Gladtfelter Harry J. Schriver ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lana Lee</u> Staben 403 Merrie Lane Fallston, MAryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Toremation 3 ☐ Removal from State Bayview Crematory 5/11/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Lice 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Road Nottingham, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2.4 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Funeral

Director

fshow

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exemination that the confederation any Injury or other traumatic event, the Medical Exemination in the confiderations.

Baltimore, Maryland 21215-0036

68760.

Records,

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Division

nding physician and use as the burial-trar by Physician/Medical Be Completed Medical Certification: To ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t

25. Was case referred to medical examiner? 1 Yes 2 No

31. Date filed (Month, Day, Year)

27. Manner of Death

1 Natural

3 🗌 Suicide

2 Accident

Hospital: 28a. Date of Injury (Month, Day, Year)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 □Yes 2 □No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

D0066102

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

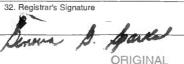
500 Upper chescipeates Drive Bel Air, IND 21014 Mohammad AFZal, MD

State Registrar

filled in by

5 Pending

investigation



09-03741 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kathleen Louise Bright State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 9, 2009 **Medical Examiner** Kathleen Louise Bright 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford 1234 Bush Road Abinadon If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Min Director 220-74-9066 04-13-1959 Country) 1___M 2 X F 50 Yrs Usual Residence of Decedent 10c. City, Town or Location any 10a. State 10b. County tant: Hitem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Harford Abingdon Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 1400 Federal Garth 21009 USA Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 2 X Married Never Married 2 X No Yes Specify: White Yes 2X Yes, Give Year No specify Widowed Divorcer 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Master Barber & Owner Tom's Barber Shop 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Jefferson Ray Helena Virginia Bartels 2 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall R. Bright (Husband) 1400 Federal Garth Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Oaklawn Cemetery 05-15-2009 Baltimore, MD Donation 5 Other Specify: 22 Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses MacPhail Rd Bel 610 W. Air. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. Intra-oral Gunshot Wound Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Medical Certification: To Be Completed by Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery

signed by the attending physician I be detached for use as the burial Division of Vital Records, P.O. Box 68760, this certificate has been s o the Hospital or Attending Physician: To the Funcral Director: completely filled in by the

past 12 months? 1 Yes 2 No 9 V Unknown	1 Live birth 4 Pregnant at time of de	2 Fetal deat	_	Ectopic pregn	ancy	M	onth	Day	Year
Part II. Other significant conditions	contributing to death but not r	esulting in the underlyi	ng cause g	iven in Part I.			e contribute		use of death?
					24a. Was an autopsy perform	,	prior deat	to complet	findings availabilition of cause of
25. Was case referred to medical			26.Place	of Death (Check	only one)	-			
examiner? 1. ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursi	ing Home 5 R	esidenc	ce 6 🗸 C	ther: Scen	е
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury FOUND: Day, Year) May 9, 2009	28b. Time of Injury FOUND: 1845 hrs		y at Work? ′es 2 ✔ No	28d. Describe ho Subject shot	e how injury occurred not self			
3 Suicide 6 Could not learning	be 28e. Place of Injury - At h		ory, office b	uilding, etc.	or Town, Sta	Street and Number or Rural Route Number, (State) oad, Abingdon, MD			
	ian: To the best of my knowled On the basis of examination a and manner stated.								se(s)
29b. Signature and title of certifier	1.16	2	O.C.N				ite signed 10, 2009	•	ay, Year)
30. Name and address of person who	completed cause of death (Item	n 23a)							
Jack Titus MD. Deputy	Chief Medical Examine	r 111 Penn Str	eet, Balt	imore, MD 2	1201				

Sarked

State

Registra

31. Date filed (Month, Days Year)

1857 hrs

10d. Inside City Limits

Yes 2 X No

Approximate Interval

Between Onset and

Death

32. Registrar's Signature

Busers

Amend Items Please Type of Print in Black Indelible in Ensure All Copies Are Legible.

For Amend Item 25 State of Maryland Department of Health and Mental Hygiene

State of Maryland Department of Death

Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 **Physician** Month Day 29 Ye 109 Rodolfo Calderon 1625 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of Maryland University Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F Director 1940 217-58**-**6536 Aug 21. **Philippines** Usual Residence of Decedent 10a. State 10b. County the Marylan 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Director 1 Yes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21202 r than "natural", or items 23a 26 E. Mount Vernon Place, #1B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 X No Specify: ģ Specify: Filipino 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer EBA Company 7 is marked other traumatic event, 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nesmesio Ruiz Calderon Blancaflor Jahel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Cecilia B. Calderon (Sister) If item 27 or other t 26 E. Mount Vernon Place, Baltimore, Maryland 21202 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department Important: If any injury o Edgewood Mem. Park 4/1/2009 Glen Mills, PA 21. Signatur of Funer | Service Circ. Se

Martin U. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Course (Size) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prostate cancer disease or condition resulting in death) PROVED BY THEORY EXAMINER /Medical Due to (or as a consequence of): Examiner Subdural hematoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Col: backerem and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Day Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown us certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury
Found Day, Year)
03/19/2009 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation atural 2 Accident Injury death. 1 □Yes 2X No Probable multiple falls ie Hospital or Attendi 24 hours after death. ie Funeral Director: A completely filled in by the Unknown 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rwal Route Number, City or Town, State) Place, #1B, Balto, MD Found: 26 E. Mount Vernon 4 ☐ Homicide Found: Home Decretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene Street, Baltimore, MD. 21201 Sheets 22 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 09 Registrar

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ì	Physici	an	1. Decedent's Name (First, Middle						2. Da	te of Death	Day Year	3. Time of Death
	/Medic	cal	42 Facility Name (If not institution	COCNE	1~		4b_City, Town, o	r Location o	177	KL 1	Ic. County of Death	2:30 PM
	Examir	ner	4a. Facility Name (If not institution	A Medica	H. Cor	NTER	()	NORL				
	Funeral				e (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under		te of Birth onth, Day, Yea	9. Birth	nplace (State or Foreign untry)
	Director		578-36-8298	1 kV M 2 L F	78	Yrs.	Wortins Days	Tiours	Feb	ruary5,	1931 Ten	nessee
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
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	th the	Director	10e. Street and Number			20 20 20	10f. Zip Code			10g. (Citizen of What Cou	intry?
	ath will	rai	17156 Red Brus	h Rd.			22827				USA	
	er des items norm	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		. 13. V	Was Decedent of H f Yes, specify Cub	lispanic Ori an, Mexican	gin? (Specify Ye n, Puerto Rican,	es or No- etc.)	14. Race - Amer Black, White,	
336	be fled within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show event, I'm Medical Exhring must be notified at	by F	1 ☐ Never Married 2 ☐ Marri 3 🔯 Widowed 4 ☐ Divorced	ed 1 □Yes 2 □ N If Yes, Give Year or Dates:	NO	1	∐Yes 2 M No	Specify:			Specify: Wh:	ite
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ar y	2 should be and Mental Is marked aumatic ev	2	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street				y or Town, State, Zi	ip Code)
	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		Keith Cochran	Son		1715	6 Red Br	ush R	d. Elk	ton, Va	22827	
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altimor	permit. Pag Department Important: I any injury c		4 Donation 5 Dother (Sp	ecify)	Koor		mily Cem	10			ge Co. Vi:	
n n	permi Depar Impor any ir		21. Signature of Funeral Service L	icensee		22	. Name and Addre	ss of Facilit	y Schim	unek Fu	ineral Ho	me
			23a. Part 1. Enter the disease, or	complications that caused	the death.						Md.21236	Approximate
· P	hysician		23a. Part1. Enter the disease, or o shock, or heart failure. List o immediate Cause (Final	only one cause on each lin	ne. Inti	raopei	rative Bl	eedin	lg Dice	100		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a con eque	ence of):	Polycysti	c Kid	$p_{\mathcal{S}}$	ease		-
· E	Examiner	L	Sequentially list conditions.	L. INTRA	10/6	VEAT	AVE	130	2000	4	. ,	
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	e, and due to t	he cause(s)	and manner as	stated.
	omple	Mec	29b. Signature and title of certifier 29c. License number		29d. Date	e signed (Month,	Day, Year)
>	->-0		Do1852	-	APA	4116	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL A, DEVORE MID Y2U3 WELN Shung Rel	trati	SVIII.	emo	2078/
	Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAULA, DEVORE MID Y2U3 CHUS Shure, Rel 31. Date filed (Month, Day, Year) MAY 1 3 2009				

Registrar

111 Penn Street, Baltimore, MD 21201 2. Registrar's Signature

and manner stated

Deputy Chief Medical Examiner

son who completed cause of death (Item 23a)

29b. Signature and title of certifier

Jack Titus MD.

31. Date filed (Month, Day, Year)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 13, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** unningham Mar 1155 PM enise 2009 03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** N/A5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 217-50-1684 59 Director 10-3-1949 NEW YORK Usual Residence of Decedent the Marylan 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show at Director 1 XYes 2 No Examiner must be notified MD. N/A BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 2208 LINDEN AVE. items 23a 21217 Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No by Specify: BLACK 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important; if item 27 is marked other the any injury or other traumatic event, the 1 once. -12-FINGERPRINT SPECIALIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEROY CUNNINGHAM EDITH E. ELEY ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNEST YATES (COMPANION) 2356 EUTAW PLACE BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cr KING MEMORIAL PARK Other 5-12-2009 BALTIMORE, MARYLAND HIBNER2. Name and Address of FacilityREDD FUNERAL SERVICE 21. Signature of Fun 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate an e (Final disease or condition resulting in death)

a. Occupie V Kemia 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi and resulting in death) Last Due to (or as a consequence of) by Physician/Medical Completed Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, I Director: After to in by the funer within 24 hours a

To the Funeral C

completely filled

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 🗌 Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlyi	ng cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Othor	•	6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 📋 Yes 2 🗌 No	28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif		ory, office	28f. Location (Street a City or Town, State	and Number or Rural Route Number,
29a. Certifier 1 Certifying Ph (check only one) 2 Medical Exam	/sician: To the best of my knowledge. On the basis of examination and manner stated.	owledge, death occurration and/or investigation	ed at the time, date and place ion, in my opinion, death occ	e, and due to the cause (urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		. 2	29c. License number	29d. Da	ate signed (Month, Day, Year)
Ruth M Pools	14.D		DO064483	Ma	
30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)			

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

Keth W

31. Date filed (Month, Day, Year) 32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G891, 5/13/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Month Physician Nevda Paulino Cabrera 3:30P M May 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Kensington Nursing Center Kensington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days May 8, 65 Domincan Rep. 224-51-5466 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 No Kensington MD Montgomery Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 20895 United States 3000 McComas Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 Married Dominican Specify: Black Baltimore, Maryland 21215-0036 1XYes 2 No Specify: þ 3 Widowed 4 Divorced Republic Completed 16b. Kind of Business/Industry th and Mental Hygiene.
7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 10 Baby Sitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cabrera Enlalia Simon Valdes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 is any Injury or other trau once. Miguel Paulino / Son 1239 Underwood St. NW, Washington D.C. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 5/11/09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services
933 Gist Ave., Silver Spring, MD 21. Signature of Fundamental Principles 23a. Part1. Enter the disease, or templications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ADENOCARCINOMA **Physician** PELVIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

12 Funeral Director: A oletely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier (my seo m) 00057124 517109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao Montgomery Medical Associates 10110 Molecular Dr. Rockville, Md 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAY 13 2009

Robert L. Carpenter, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar				Certific	ate of	Death				Reg. No			
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3.											3. Time of Death		
ledical Exam	iner	ROBERT L.	CARPENTI	ER, JR.							May 1,	2009 Day	rea		1757 hrs
		4a. Facility Name (if not	institution, gi	ve street and n	umber)		41	c. City, Town, or		Death			c. County o		
		7005 Oliver Bea	ach Road					Middle Rive	r				Baltimor	e Cou	nty
Funeral		5. Social Security Numb	er 6. S	Sex	7. Age (In	yrs. last birt	hday)	If Under 1 Year			8. Date o	f Birth (MM	/DD/YYYY	9. Birth Foreign	nplace (State or
Director		217.76.0196	15	XM 2 F		50	Yrs.	Months Days	Hours	Min.	MAY	25, 19	58		intry) MD
		Usual Residence of Dec						<u> </u>							
/ any		10a. State 10b.	County		100	. City, Town	or Locatio	n							10d. Inside City Limits
Aaryland 28a-f show 1. at once.	=	MD	BALTIMO	RE		MONKTO	N								1 Yes 2 No
laryla 28a-f atog	Sct	10e. Street and Number						10f. Zip Code				10g. Ci	tizen of Wh	at Coun	
the M tor 2 iffied	Director	2515 SHEPHE	EDU DU					21111					US	Α.	
with ns 23; ne no	<u>a</u>	11. Marital Status	CRD RD.	12. Was De	cedent Eve	r in U.S.	13. Was	Decedent of His	panic Origin	n? (Spec	ify Yes o	r No-			can Indian, Black,
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married	2 Marrie	d Armed F		No	If Ye	s, specify Cuban	, Mexican, F	Puerto Ri	can, etc.)		White	e, etc.	
		3 Widowed 4	4 XX Divorce	d If Yes, Give Ye	2 XX ar	INO	1 .	Yes 2 XX No	specify:				Specify:		WHITE
ours a atura camir	d by	15. Decedent's Educat	tion (Specify	or Dates: only highest gra	de complet		Decedent'	s Usual Occupati	on (Give ki			16b.	Kind of Bu		
5 72 ho n "na al Es	Completed	Elementary/Secondar	ry (0-12)	College (1-4 or 5+)		during mo:	st of working life.	DO NOT u	se retired	4)				
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5-0 led w Tygie othe	ပြ	17. Father's Name (First	t, Middle, Las	t)					8.Mother's	Name (F	irst, Midd	le, Maide			
21 be fil ntal I	Be	ROBERT LEO C	CARPENTE	R, SR.					SHIRLE	EY HO	RNING				
21 nould id Me is mal	P	19a. Informant's Name/F	Relationship (Type, Print)		191	. Mailing	Address (Street	and Numb	er or Rur	ral Route	Number, (City or Town	n, State,	Zip Code)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland teath and Merial Hygiene. The 21 is marked other than "unatural", or items 23a or 28a-f she item 21 is marked other than "unatural", or items 23a or 28a-f she it raumatic event, the Medical Examiner must be notified at once		KIMBERLY ANN				1 7	742 EL	MHURST RD	. SEVER	RN, MI	2111	4			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after begarment of Health and Morella Hygelmortant; If item 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or To										Town, State			
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Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		21/Shinature of Funeral Service Licins 2 22. Name and Address of Facility										, (III)			
E E E E		K. GREGORY		+	MI	71148	426	CRAIN HWY	HUME, / SW GL	EN BL	JRN I E .	MD 2	1061		1
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687 ertific ding p	an/	23b. Was decedent pregr past 12 months?	nant in the	1 Live	birth	2	Feta	I death 3	Ectopic p	pregnanc	;y		Month	D	ay Year
Box e death of the attented for us	sici	1 Yes 2 No 9	Unknow	. ' = '	nant at time	of death	Othe	er (Specify)							,
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of Vital Records, g Physician: The law requir- ufter this certificate has been si neral director, page 2 should b	To B	examiner?	No	Hospital: 1	Inpatient	2 ER/0	utpatient	3 DOA	Other4	Nursing I	Home 5	Resid	ence 6 🔻	✓ Other:	: Scene
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Division as or Attendiums after death. al Director: A led in by the fu	읥	1 Natural 5	Pending Investigat		,, , ,			1_ Y	es 2 N	No					
ivision or Attendafter death Director:	ı <u>ÿ</u>	3 Suicide 6		28e Plac	e of Injury	- At home, fa	rm, street	factory, office bu	uilding, etc.	28			and Numbe	er or Ru	ral Route Number, City
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Hos 24 hc Fun etely	<u>=</u>	29a. Certifier 1 Certi	ifying Physic	ian: To the be	st of my kno	wledge, dea	th occurre	ed at the time, da	te and place	e, and du	ue to the	cause(s) a	nd manner	as state	ed.
Division of Vital Records, P.O. Box 68760, within 24 hours after death. The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	Medical		ical Examine	r:On the basis		tion and/or i	nvestigatio	n, in my opinion,	death occu	urred at th	ne time, c	late and p	lace, and d	ue to the	e cause(s)
- × + ŏ	Me	29b. Signature and title of	of certifier		/	1	/	29c. License	number			29d	. Date signe	ed (Mor	nth, Day, Year)
		16/11	11	115	7	1		O.C.N	Л.E.			Ma	y 2, 200	19	
1,		30. Name and address o	of person who	completed cau	se of death	(Item 23a)		<u>r</u>				L			
41		Zabiullah Ali, M.	.D. Ass	istant Medic	cal Exam	iner 11	1 Penn	Street, Balti	more, M	D 2120	01				
St	ate	31. Date filed (Month, Da			egistrar's S	gnature								•	
Regist	trar	MAY 1	3 2009	Dene	M	A. 1	ark								

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of	Maryland /		rtment of H			-	giene Reg. No	2000	15403
			Decedent's Name (First, Midd	fle, Last)					I	2. Date of De	ath		3. Time of Death
	Physici /Medi		BESSIE SAVIN CART	TER						Month MAY 7,	2009	ıy Year	9:15 P M
-	Examir		4a. Facility Name (If not institution	on, give street and numi	ber)		4b. City, Town, or	Location	of Death		4c	. County of Dea	th
1			BRINTON WOODS NUR	RSING & REHAB			WOODBINE					CARROLL	
	Funeral Director		5. Social Security Number 212.05.2325	6. Sex 1 M 2 XF	. Age (In yrs. last 94	birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bir (Month, Da	ı <i>y, Y</i> ea <i>r)</i>	Co	thplace (State or Foreign ountry) MD
	pu ,		Usual Residence of Decedent 10a. State 10b. Count		100 Ciby To	nun or Lo	nation				_		10d. Inside City Limits
	show	٦			10c. City, To		cation						1 □Yes 2 No
	he M	ecto	MD CARROL 10e. Street and Number	L	WOODBI	NE	10f. Zip Code				10a Ci	tizen of What Co	
	with 1	ä									109. 01		
	eath	era	1442 BUCKHORN RD. 11. Marital Status	12 Was Deced	ent Ever in U.S.	13. \	21784 Was Decedent of Hi	ispanic C	rigin? (Spe	ecify Yes or No)-	14. Race - Ame	erican Indian,
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evariner must be notified at	by Funeral Director	1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried Armed Ford	No B		Mas Decedent of Hi fYes, specify Cuba I∐Yes XX No	n, Mexica Specif		Rican, etc.)		Black, Whit Specify:	
0-10	2 hou	ted	15. Decede	nt's Education	1	6a. Dece	dent's Usual Occupa	ation	et of worki	na	16b. K	(ind of Business	
218	hin 7 an "n	ed l	(Specify only night	est grade completed) College (1-4	for 5+)	life. I	kind of work done of OO NOT use retired	iunng mo l)	ISLOI WOFKI	ng			
21	d wit	Completed by	8			HOM	EMAKER					WN HOME	
nd	should be filed within and Mental Hygiene. marked other than imatic event, the Mental Hygiene.	Be (17. Father's Name (First, Middle	, Last)				18. Moti	ner's Name	(First, Middle	, Maider	n Surname)	
<u>yla</u>	Men Arker arker atic	၉	ZUETA SAVIN							INE KOTRA			
/ar	2 should I and Men Is marker		19a. Informant's Name/Relation	ship (Type. Print)	1		g Address (Street a						Zip Code)
е,	ges 1 and 2 should t of Health and Mer if item 27 is marke or other traumatic		JOYCE MCGARRY 20a. Method of Disposition		20h Plant		GATEHOUSE (sition (Name of	COURT		VILLE, MI		.ocation - City or	r Town State
Baltimore, Maryland	permit. Pages ' Department of I Important: If ite any Injury or of once.		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (tate ceme	etery, cren	CEMETERY, II		5.12.2			BURNIE,	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service K. GREGORY	The I when	M011	48 42	NAME AND Addres INK FUNERAL 26 CRAIN HW	HOME Y SW	, P.A. GLEN B	URNIE, MI	210	61	
			23a. Part Enter the disease, of shock or heart f Ture. Lis	con plications that can	used the death. [Do not ent	er the mode of dyin	g, such a	s cardiac	or respiratory a	ırrest,		Approximate Interval Between
5	Physician	8 9	Immediate Cause (Final disease or condition	at thy one cause on ea	1 Lucas	Don	oxiceles	All	leut	6-			Onset and Death
	/Medical		resulting in death)	Due to (o	r as a consequen	ce of):	Craft w 8		300-0-1				7
	Examiner		Convention live link conditions	b		U							· ·
1	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consequen	ce of):							
UP.	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
30,	be excian gurial-	Ē	resulting in death) Last	Due to (o	r as a consequen	ce or):							
8760,	icate be executed physician and s the burial-transit	dical		d									
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy		75-1					23d. Date of de	elivery
W.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		rth 2 ☐ Fetal de ant at time of deat		Dectopic pregnancy Other (specify)	y 				Month	Day Year
P.0	uires that the de signed by the d be detached to	hys	9 ☐ Unknown							T			
Ś	es thi		Part II. Other significant condit	lons contributing to dea	th but not resultin	g in the u	nderlying cause give	en in Parl	t I.				to the cause of death?
ord	w requir	ted	- Dav	sur lace	17	1				14	Yes 2	2 [2/No 3 ☐ F	Probably 4 Unknown
of Vital Records,	e law has b	Completed by	Ples	sulal V/15	allan	DIG	COLOP			24a. Was auto	an psy ormed?	24b. Were a prior to	autopsy findings available completion of cause of
F	cate ha	ပ်	. 0							1 □ Yes	2 AN	death? 1 ☐ Ye	s 2 19 No
Vita	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	al Hospital:			Oth	or:	/	(Check only			
of	Phys this al dir	၉	1 Yes 2 ₹No	28a. Date o	patient 2 ER	Outpatier		4 14/1				6 ☐ Other (Spi	ecify)
n C	iding Physician: th. After this certifical funeral director, p	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	ing (Month	, Day, Year)	Injury	Work	yat (? Yes 2[28d. Describe	now inju	iry occurred	
isi	death death stor: / the	icat	3 ☐ Suicide 6 ☐ Could		of Injury - At home	farm str		165 21		28f. Location /	Street a	and Number or F	Rural Route Number,
Division	after Direct	Certification: To	4 ☐ Homicide deter	mined building	g, etc. (Specify)	,,	ooi, idololy, amou			City or To	wn, Stat	te)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C		ing Physician: To the to Il Examiner: On the ba	sis of examination								
	To the To the	Me	29b. Signature and title of certific				29c License	e numbe	r		29d. Da	ate signed (Mon	nth, Day, Year)
			· Katuch	Tillesus)		02	Ofe	16		5,	/11/200	7
	3		30. Name and address of person	n who completed cause	of death (Item 23	Ba) (Type,	Print)	.0 .1	711	ON 5	- A	OSRIDE	111) 7/700
	~		31. Date filed (Month, Day, Year	1 32 00	gistrar's Signature	102	11.000 L	11500	471	D C	130)	SPUKO 1	0 01789
	Sta Registi		he a v = A	1000	g.o., a. o. o.griature	bar	V. 8						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#15&19a, perINF, G891,5/18/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 8, Joseph Michael 1 Clayson 2009 10:10PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Co. 8436 Coco Road Rosedale 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours Min 1**X** M 2□ F Days Director May 8, 82 1927 217-22-2556 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits ns 23a or 28a-f show Director 1 ☐ Yes 2 ANo Roseda1e Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 8436 Coco Road United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No d other than "natural", or items event, the Madest Event 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 21 No Specify ģ Specify: 3 ₩ Widowed 4 Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. In Maren. Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) unkn. 18. Mother's Name (First, Middle, Maiden Surname) Be Clayson Nettie Carrico ပ 19a. Informant's Name/Relationship (Type. Print)

Mary Ann Bare (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7326 Manchester Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gdns. of Faith Cem. 5/12/2009 Rosedale, Maryland 4 □ Donation 5 ▼ Other (Specify) Entombmen 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. why 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown þ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate performed? Division of Vital 2**X** No 2 🗆 No 1 □Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1KDYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending Injury 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) 6 Trimble Hill Ct. Lutherville, MD Philip Militello, M.D. 21093

State Registrar 31. Date file (Month, Pay, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible lak TEnsure All Copies Are Legible.
Amend #2, per MD 693 Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Physician illian 2008 Car MAY /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltin Idallstown HOSPICE - Northwest Kar pre If Under 24 Hrs. 5. Social Security Number 6 Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 219.22.582 1 □ M 2 X F Months Days Hours Min MID 80 Yrs. Director 05/31 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examinar must be notified at anones. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits MD Battimore Baltimore 1 ☐ Yes 2 XNo **Funeral Director** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3223 Elba Drive 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗷 No If Yes, Give Year or Dates: þ Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) state of Manyland College (1-4or 5+) Elementary/Secondary (0-12) Clerk Social Services 12th grade 17. Father's Nam (Pirst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brown Ida Ma じかび 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kangalee/Daughter 3 Wellhaven Circle Apt. 1224 Owing Nills MD 2117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 15/04 051 Owinas Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughor C. Greene Fungray SVCS C. Vani andall stown MD 21132 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician MESO THEZIOMA disease or condition resulting in death) MALIGN/MYT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an 1 ☐ Yes 2 V No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify NS 10 P (1-Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person mith Avenue Sure 208

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amends tate of Mary Pand Prepartment of Health and Mental Hygiene Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Martha Theresa Ciesla 2009 7:30a May 8 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 717 50th Street Dundalk Baltimore Co. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min Director 215-28-2652 78 8-27-1930 Indiana Usual Residence of Decedent 10c. City, Town or Location show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2X No MD Baltimore Co. Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 50th Street 21224 Pages 1 and 2 should be filed within 72 hours after death vector of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s ury or other traumatic event, Ite Mo Acol Exa rilvet must Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🔀 No Completed by Specify: Specify: White 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A <u>Home Maker</u> Home 17. Father's Name (First, Middle, Last)
Peter Venalainen
Peter Venalinen 18 Mother's Name (First, Middle, Maiden Surname) Anna Zellinger Ana Zellinger Be ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Carrico-Daughter |4951 Alesia Lineboro Rd.Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any Injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 5-12-09 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA Plubor 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Stroke and Due to (or as a consequence of) aftending physician for use as the buria Physician/Medical Hyperlipidemia as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Parkinson's Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 🛛 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ဂ္ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ∩ 24 hou. the Funeral Dire within 2

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

Simon V.

Scalia, 2801 Hudson Street Baltimore, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

D 24276

29d. Date signed (Month, Day, Year)

2009

May 11,

			1 - For 4-23-09, BW State 4-23-09, BW Registra WEND#23a-1	.Man			artment of H rtificate of L		-	giene Reg. No.2	009	15407		
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath Day	Year	3. Time of Death		
4	/Medic			Todd Russe		ıdelin			Apri1	18	2009	8:52 a _M		
	Examin	er	4a. Facility Name (If not institution		•		4b. City, Town, or		ath	4c. Cour	nty of Death			
	Francis	•	Shady Grove Adve 5. Social Security Number			last birthday)	If Under 1 Year	ockville If Under 24 Hr	rs. 8. Date of Birt	th	Montgo 9 Birthn	Dmery lace (State or Foreign		
	Funeral Director		218-15-4210	1 ⊠ M 2□ F	36	Yrs.	Months Days	Hours Mir	n. (Month, Da	y, Year) 4, 1972	Coun	Maryland		
			Usual Residence of Decedent											
	arylan show	-	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				11	Od. Inside City Limits		
	he Ma	Director		tgomery				therburg				1 □Yes 2 No		
	a or 2		10e. Street and Number	-1-1-77			10f. Zip Code	00070		10g. Citizen o		•		
	ns 23	Funeral	11515 Su11	12. Was Deceden	t Ever in U	S. 13.	Nas Decedent of Hi	20878	(Specify Yes or No	- 14 B	U.S.A			
ယ	r iten	Fun	1 X Never Married 2 Marri	Armed Forces ed 1 □Yes 2 😿	?		Was Decedent of Hi f Yes, specify Cubar		erto Rican, etc.)	В	lack, White, 6			
ğ	ral", o	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			I∐Yes 2⊠No	Specify:		Spec		Caucasian		
2	72 hc	Completed	15. Decedent (Specify only highes	's Education t grade completed)			dent's Usual Occupa		orkina ı	16b. Kind of	Business/Inc	lustry		
121	vithin ene. than '	I I	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retired;) -		C	C			
d 2	be filed within 72 hours after death with the Maryla ital Hyghene. do other than "natural", or items 23a or 28a-f shou event, it with Macken Franciscom ust be notified a		12 17. Father's Name (First, Middle, L	Last)			Mail Cl		ame (First, Middle,		tract Se	ervices		
au	d be ental ked o	To Be		11 R. Daudelii	n				Linda An		,			
ary	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exemple must be notified at	۲	19a. Informant's Name/Relationsh		<u></u>	19b. Mailir	ng Address (Street a	and Number or I				Code)		
Σ			Russell R. Daudel	in - Father		115	15 Sullnick	Way, Gai	thersburg,	Marylan	d 20878			
ore	ges 1 and nt of Healt if item 27 or other 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Pamoval from State	20b. F	Place of Dispo emetery, cren	sition (Name of natory or other place	e)	Date	20c. Location	n - City or To	wn, State		
Ē	. Pages tment of tant: If its jury or o	9	4 □ Donation 5 □ Other (Sp	ecify)		rklawn M	emorial Par	k 04/	/22/2009	Rockvi	lle, Ma	ryland		
Baltimore, Maryland 21215-0036	permit. Pages. Department of Important: If ite any injury or of once.		21. Signature of une 1 Service L	N Vetus	a	H 1	. Name and Addres ines-Rinald 1800 New Ha	s of Facility i Funeral mpshire A	Home, Inc.	ver Spri	ng, Mary	vland 20904		
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that cause	d the death							Approximate Interval Between		
M.	Physician		Immediate Cause (Final disease or condition			Pneumoni	a		//			Onset and Death Days		
A	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	uence of):		^						
	- Autilition	<u>.</u>	Sequentially list conditions,	b. Subdut	ral Hen			11/	1	- VANNE				
)	uted nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000.10 (01.0)	e a eurineeqi	uoritie Orj.		1/	DOVED BY MED	ICAL EXAMINER				
~	execun and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as	s a consequ	uence of):		CERTIFICATION	APPROV					
8760	cate be executed physician and the burial-transit	dical	•	d				W. /	₹ 					
9	certifica nding ph ise as th	യ	IF FEMALE:	1										
ХOЯ	death certific e attending p	sician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Feta	Ideath 3 □	Ectopic pregnancy			10	Date of delive Month	ry Day Year		
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of d	leath 5	Other (specify)	· .		'	VIOLITI I	Day Teal		
<u>. </u>	that the the ed by detac	Phys	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the ur	derlying cause give	n in Part I.	23e. Did to	obacco use co	ntribute to th	e cause of death?		
Hecords,	w requires that the de s been signed by the should be detached	d by	Liver Disease						1 🗆 Y	∕es 2∐No	3 ☐ Prob	ably 4 🔀 Unknown		
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ř	The law te has	E I								rmed?	prior to cor death?	npletion of cause of		
VITAI	ian: '	Be C	25. Was case referred to medical examiner?					26. Place of De	1 ☐ Yes eath (Check only o		1 □Yes	2 □ No		
> 	hysic his ce I dire	2	1 XYes 2 No	Hospital: 1 ☒ Inpat	ient 2 🗆	ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursing	Home 5 Resid	lence 6 🗆 C	ther (Specify)		
ב	ing P	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		ury ay, Year)	28b. Time of Injury	Work	?	28d. Describe h		urred			
VISIO	death death stor: / the f	icat	Accident investigated investigated a line of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second o	ot be 280 Place of In	09	1200	M 1 □Y eet, factory, office	′es 2.∏xNo =	Syncopal Syncopal	Łpisoe				
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_	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	edical C	29a. Certifier (Check only one) 1 🕱 Certifying 2 Medical E	Physician: To the best examiner: On the basis	of examina	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and pla pinion, death occ	ce, and due to the	cause(s) and	manner as st	rersburg,Md tated. the cause(s)		
	To the	Med	29b. Signature and title of certifier.	you manners			29c. License	number		29d. Date sigi	ned (Month, L	Day, Year)		
	3		110	Yn	M.I	2.	D00	651	32	April	18, 20	09		
	9	Ì	30. Name and address of person w	•			Print)			r	-,			
			Wei Zhang, M.D.				ite 33, Arli	ington, V	A 22203					
	Stat Registra		31. Date filed (Month, Day, Year) APR 21	2009 Seneu	rar's Signat	h. Spa	Wed.							

		State of Mary 1 - State Amend Item 29d per dr. 1. Decedent's Name (First, Middle, Last)	land / Depa , g891 , 05/	artment of I 13/09dhb Tincate	Health and Death	Mental Hyg R 2. Date of Deat		09 15408			
Physic /Med Exami	ical		EWATE		r Location of Deat	Month 05	Day / U 4c. County	Year 0338 M			
LAdilli	illei	Anne Arundel Medical Center	r i		polis	.,		ne Arundel			
Funera Director	_	5. Social Security Number 520–56–6335 Usual Residence of Decedent	n yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day APR 4, 1	951	9. Birthplace (State or Foreign Country) Wisconsin			
Maryland 1-f show Incd at	tor		c. City, Town or Loc	cation Prince	ce Frede	rick		10d. Inside City Limits 1 □ Yes 2 No			
th with the 23a or 28a	Funeral Director	10e. Street and Number 24 Paulowinia Lane		10f. Zip Code	20678	1	0g. Citizen of V	What Country? JSA			
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a New Yorl Eventual to rotified at	by Fune	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates;	li li	Was Decedent of H f Yes, specify Cuba I □Yes 2 XNo	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - American Indian, k, White, etc.			
21215-0036 within 72 hours aff giene. er than "natural", or if the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	dent's Usual Occup kind of work done OO NOT use retired	during most of wo	rking	 16b. Kind of Bu	White siness/Industry			
d 2121 filed within Hygiene. other than '		2	Comp	uter Pro				outers			
Maryland od 2 should be file lith and Mental Hy 27 is marked oth	To Be	17. Father's Name (First, Middle, Last) Clarence L. Drinkwate	er		18. Mother's Nar Joan	me (First, Middle, N	faiden Surnam Turr e	•			
larylan 2 should be and Mental is marked o	ř	19a. Informant's Name/Relationship (Type. Print)		g Address (Street		ural Route Number					
Te, March 1 and 2 Health a tem 27 is other trans		Margaret M. Drinkwater, wife			Prince 1	Frederick	, MD 2	20678			
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	-	natory or other plac		_		City or Town, State			
altin mit. Pa partme cortant Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee George Mac	Metro Crei					ore, MD of MD, Inc.			
Depa Depa Impo		Leon E Mar de		299 Frede	erick Ro	ad Bal	timore,	MD 21228			
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	chro	er the mode of dyir			est,	Approximate Interval Between Onset and Death			
Examiner	ı	Due to (or as a co	nsequence of):	F	HW			ulen			
68/60, ificate be executed g physician and is the burial-transit	al Examiner	Sequentially list conditions, it say, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conditions).					year				
death certi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 ☐ e of death 5 ☐	Ectopic pregnanc Other (specify)	,	The second	23d. Date Moi	e of delivery nth Day Year			
The law requires that the law been signed by the age 2 should be detached.	b	Part II. Other significant conditions contributing to death but no	t resulting in the un	derlying cause give	en in Part I.			ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown			
	e Completed	25. Was case referred to medical			00 Plant (P)		ned? d	Vere autopsy findings available prior to completion of cause of leath? ☐ Yes 2☐ No			
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Adatural 5 Pending (Month, Day, Yes) 2 Accident Investigation	2 ER/Outpatient 28b. Time of Injury	28c. Injur Work	er: 4 🗆 Nursing H	ath (Check only one dome 5 Reside 28d. Describe ho	nce 6 Othe				
To the Hospital or Att within 24 hours after dt To the Funeral Direct completely filled in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S)	pecify)			City or Town	, State)	er or Rural Route Number,			
he Hosp in 24 hot he Funel pletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 1 Medical Examiner: On the basis of examiner stated.	/ knowledge, death mination and/or inv	occurred at the tir restigation, in my o	me, date and place pinion, death occu	e, and due to the caurred at the time, da	ause(s) and ma ate and place, a	nner as stated. and due to the cause(s)			
To ti withi To ti	M	29b. Signature and title of certifier	Mum	29c. License	e number	38	Od. Date signed	10/2009 ^{Year)}			
		30 Name and address of person with completed cause of death C (1) C (2) C (3) C (3) C (4)	A MO.	Print) 445	DEFE	NSE 14	IG HW	Ay ANNAPUS MY			
Sta Regista		MAY 1 3 2000	A ba	Men!				2160			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month RO /Medical Day 2009 4a. Facility Name (If not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Greneral Jakyland Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Director 704ary 19, 1938 TARY And Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or items 23a or 28a-f show State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥Yes 2 No AR gland IMORE Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2121 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 € 1 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: AMERICAN 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kin of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Schods 124 DALLMORE City Nutrition DERVICES Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) Be ပ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BAILIMORE Sheena MARYland 21216 other 1820 Moreland Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State MAY16,2009 4 Donation 5 DOther (Specify) 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility Nancy m. Wallace 3405 W. FRANKLIN Street BAHIMORE MARYLAND 23a. Part 1. Enter the disease shock, or heart foure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fival disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner eumona Sequentially list conditions Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last enia Neutro and Due to (or as a consequence of) Box 68760, physician the death certificate be Physician/Medical the as attending | JF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy or in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Ö the detached 9 Unknown 9 Unknown ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy this certificate perform of Vital 2 🗷 No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital ဂ္ 1□ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending Injury ithin 24 hours after conditions the Funeral Director: A death. investigation 1 □Yes\2 □No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely 29b. Signature and title of certifier 29c. License number ပ 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Hame and address of ladela Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

LOLA DEMINIA DOO: 5/5/04 TOO 9:49.PM Baltimore, Maryland 21215-0036 Demit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland

Division of Vital Records, P.O. Box 68760,

	_	For State		State	of Mai	ryland /		artment - rtificate		ealth and	Mental H		0000) 1	F1 1 C
		Registrar 1. Decedent's Nam	ne (First Middl	a lasti			Cer	uncate	OI L	Jeatri 	2. Date of I	Reg. No.	200	2 Tin	ne of Death
Physicia: /Medica		Lola Ma		. ,							Month May		2009 Year		:49 PM _M
Examine	r	4a. Facility Name (number)			4b. City, To	wn, or	Location of Deat			County of Deat		
		5. Social Security N		6. Sex	7 Age	(In yrs. last bi	irthday)	If Under 1	Year T	Silver If Under 24 Hrs.	•		Montgom	-	ate or Foreign
Funeral Director		215-38-		1 □ M 2 📈 I		67	Yrs.		Days	Hours Min.	(Month, 10/	Day, Year) 07/19	41 D	untry)	
and w	ŀ	Usual Residence o 10a. State	f Decedent 10b. County			10c. City, Tow	n or Lo	cation						10d. Insid	de City Limits
Maryli f sho	<u>ē</u>	MD	Mont	comery		•		Spring							Yes 2 No
r 28a	Director	10e. Street and Nu		,				10f. Zip C				10g. Citi	izen of What Co	untry?	
th with	ا <u>م</u>	308 Ell	.sworth	Dr.				20	910	_		Ur	nited St	ates	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Its Medical Exprining must be notified at once.	by Funeral L	11. Marital Status 1 Never Marr 3 Widowed		ried Armed	Decedent Event Forces? Solve Sive Dates:		1	Was Deceder If Yes, specify 1 □Yes 22	y Cubar	spanic Origin? (S n, Mexican, Puerl Specify:	Specify Yes or to Rican, etc.)	No-	14. Race - Ame Black, White Specify: W		ın,
2 hou	Ted Ted	10	15. Deceden	t's Education		16a	a. Deced	dent's Usual (Occupa	ation		16b. Ki	nd of Business/	Industry	
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d be f ental l ked of	0 26	Herman								Virgin			odinamoj		
nd 2 shoul		19a. Informant's N	lame/Relations			19				nd Number or Ri					
Pages 1 ar	ĺ	20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation	3 ☐ Removal fro	om State	cemete	ery, cřen	sition (Name natory or othe	er place		Date May 7 2009		ocation - City or		
permit. Departm Importa any Inju		21. Signature of Fu			M	00382	-	. Name and	Addres	s of Facility ral & Cre			ces Maryland	2091	0-
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/Medical Examiner	ner	Sequentially list co liany, leading to fin cause. Enter Unde Cause (Disease or		b		consequence				, ,	1			-	
	EXA	Cause (Disease or that initiated events resulting in death)	S	c	to (or as a	consequence	of):								
	egicai			a				-							
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/ini	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 □ Li 4 □ P	ive birth 2	f pregnancy Fetal deatl ime of death		Ectopic pred Other <i>(spe</i> c				-	23d. Date of de Month	livery Day	Year
w requires that the dispersion signed by the should be detached	2	Part II. Other signi	01	ons contributing to	o death but	not resulting	in the ur	nderlying cau	ise give	n in Part I.			use contribute to		e of death?
sician: The law req	Completed										24a. W au pe 1 □ Ye:	topsy rformed?	prior to death?	completion	ings available of cause of
clan: ertific ector,	90	25. Was case refer examiner?	rred to medical	ř .					1	26. Place of Dea	ath (Check on	y one)			
this of all dire	2 │	1 Yes 2			☐ Inpatien			nt 3 DOA		4 L Nursing F	1		6 □Other (Spe	cify)	
ending Physician: sath. or: After this certifica he funeral director, p	allon:	27. Manner of Deat 1 Natural 2 Accident	5 □Pendin investi	g (A gation	ate of Injury Month, Day,		Time of Injury	M 28c	i. Injury Work 1 □ Y	rat ? ∕es 2 ⊡No	28d. Describ	e how injur	y occurred		
tal or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □Could indeterm	ined 286. Pla	ace of Injury uilding, etc.	y - At home, fa (Specify)	arm, stre	eet, factory, o	office			(Street an Town, State	nd Number or R	ural Route	Number,
	Medical	29a. Certifier (Check only one)	Certifyir 2 Medical	ng Physician: To Examiner: On th and r	the best of ne basis of e nanner state	examination a	je, death nd/or in	n occurred at vestigation, ir	the tim	ne, date and plac pinion, death occi	e, and due to t urred at the tin	he cause(s ie, date and) and manner a d place, and due	s stated.	use(s)
To t withi Com,	1	29b. Signature and	title of certifie	1/01.000	- (dain	1	29c. L	License	3159		29d. Da	te signed (Mont	h, Day, Ye	ar) 9
(e V		30. Name and add	ress of person	who completed c	ause of dea	ath (Item 23a)	(Type, I	Print)	er a	ve S	Loen "	200	na Mi	D 2	0810
State Registra		31. Date filed (Mon	nth, Day, Year)		2. Redistrar	S Signature	1	back	/	, , , , ,		711	,,,		- 4/-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

09-03716 Marie Duff Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arie Duff		1- For State	ate of Maryl		artment of artificate of		and	Menta	al Hygie		g. N o.	20	09	154
Physici		Registrar 1. Decedent's Name (First, Midd			ate of Deat	n	Year	3. Time of						
ledical Exam		MARIE DUFF							M	ionth ay 8, 200			1730	hrs
1		4a. Facility Name (if not institution	on, give street and r	number)	4	b. City, To			Death			ounty of Dea	th	
		Calvert Memorial Hos	pital			Prince						vert		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24Hrs. 8. Min.	Date of Birt	h(MM/DD	Fore	sirthplace (St eign	
Director		234.37.7862	1 M 2 XXF		35 Yrs.		Days	Tiours		UNE 2,	1973	C	Country) GER	MANY
		Usual Residence of Decedent											T 10d Janie	le City Limits
v any		10a. State 10b. County		10c. Cit	y, Town or Locati	on								
Aaryland 28a-f show any 1 at once	٦	WV MON	ONGALIA	WE	STOVER									es 2 No
Maryl 28a-4	Director	10e. Street and Number				10f. Zip C	ode			11)g. Citizei	n of What Co	ountry?	
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shmante event, the Medical Examiner must be notified at once	<u>و</u>	19a. Informant's Name/Relations			19b. Mailing	Address	(Street	and Numb	ber or Rura	Route Nur	nber, City	or Town, Sta	te, Zip Code	*)
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Physician		23a, Part I, Enter the disease, o	r omplications that	t caused the dea	th. Do not enter t	ne mode of	dying, s	uch as ca	ardiac or res	spiratory arr	est, shoc	k, or heart		imate Interval en Onset and
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raminer	l	or condition resulting in death)		a consequence										
		Sequentially list conditions,	b										-	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		s a consequence	e of):									
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687 ertific ding p	an/	23b. Was decedent pregnant in past 12 months?	,	e birth		etal death	3	Ectopic	pregnancy	,	١	M onth	Day	Year
OX Sath c	sici	1 Yes 2 No 9 🗸 Ur	line avec	gnant at time of known	death 5 Of	ther (Spec	ify)							
	Physician/M	Part II. Other significant cond			t resulting in the	underlying	cause giv	ven in Pa	art I.	23e. Did	obacco u	se contribute	to the cause	of death?
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Divis Hospital or A 24 hours after Funeral Dire		4 Homicide	(0)000		- d d db		time det	to one nic					-	
To the Hos within 24 h To the Fur completely	Medical	(Check only 1 Certifying I one) 2 Medical Ex	Physician: To the taminer:On the bas	best of my knowl is of examination	eage, aeath occu n and/or investiga	irea at the ition, in my	opinion,	death oc	ccurred at the	e to me cat ne time, date	and place	ce, and due t	o the cause(s)
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\bigcirc		30. Name and address of personal Ana Rubio MD. As	on who completed c ssistant Medica		em 23a) 111 Penn :	Street. F	altimo	re, MD	21201					
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			■ _ State	Department of Health and M Certificate of Death		711119	15412
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Dertificate of Death	Reg. I	No.	3. Time of Death
	Physici		C Di	ckson		Day 2009	5:45 A M
	/Medic Examin		Grace B. D1 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
J	-Admin		Glen Burnie Health & Rehab. Ctr.	Glen Burnie	2	Anne An	rundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	arl Cou	place (State or Foreign ntrv)
	Director		215-28-7521 88	Yrs. Montale Baye Missile Mini.	Sept. 11,		ginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Mary f she	tor	Maryland Anne Arundel	Pasadena			1 ∐Yes Ž\∑X No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	h with	al D	7838 East Shore Road	21122		United Si	tates
	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, the Wichol Evan Instruction of the 2 at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	can Indian,
ð	after or its	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No	1 □Yes 2X No Specify:	ilican, etc.)	Black, White, Specify:	etc.
5-003	ural",	d by	3 Midowed 4 □ Divorced Year or Dates:			1	√hite
2	"nat	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)	ng 16b.	. Kind of Business/In	dustry
717	withii iene. than	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Years	Homemaker		O II	
-	be filed within 72 ho hal Hygiene. d other than "natul event, in mydical	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	Own Home len Surname)	3
yland	should be f and Mental s marked of umatic eve	To B	James Beck	Ic	la Dowell		
ary	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the m	_		Mailing Address (Street and Number or Rura			,
, Ma	and 2 ealth n 27 i		Sharon Lee (Daughter) 7	838 East Shore Road	Pasadena,	Maryland	21122
ore	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic er once.		20a. Method of Disposition 12□ Burial 2□ Cremation 3□ Removal from State 20b. Place of cemeter.	Disposition (Name of py, crematory or other place)	ate 20c.	Location - City or To	own, State
Ě	Pag ment ant: I		4 Donation 5 Other (Specify) Gard	ens of Faith Cem. 5/1	.4/2009	Baltimore	, Maryland
Бантто	permit Depar Import any In once.		21. Signature of Emeral Service Licens	22. Name and Address of Facility Duda-Ruck Funeral I	Home of Du	ındalk. Tr	ıc.
	e o		(illest) les	7922 Wise Ave. Dun	<u>dalk, Mar</u>	yland 21	222
		1 10	23a. Part 1. Enter the disease, or complications that daused the death. Do r shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	NIA			DAYS
	/Medical Examiner		Due to (or as a consequence of	rf):			Venne
		Ē	Sequentially list conditions, if any leading to immediate	47 /			YEARS
	uted d insit	Ë	cause. Enter Underlying Cause (Disease or injury				Č
'n	exec	Examiner	that initiated events c	f):			
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8	rtifica ng ph as th		UT TERMALE.				
Š	Physician: The law requires that the death certificate be executed tribic certificate bas been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deliv	
	e dea the at red fo	sici	1- Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
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Ď,	ires the signe	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		\	bably 4 Unknown
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ย	e faw has l je 2 s	Completed by	MYPERION		24a. Was an autopsy	prior to co	opsy findings available of
<u> </u>	n: Th ficate r, pag		ELEVATED CHOLEST	EROL	performed 1 ☐ Yes 2 🔀		2 □ No
=	sicial certi recto	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			
5	Phy er this eral di	<u>ان</u>	1 Yes 2 No	patient 3 DOA 4 Anursing Hor	ne 5 Residence		fy)
5	ading th. : Afte	ţi		jury Work? M 1 □Yes 2 □No	od, Decoribe flow in	ijary occurred	
2	Atter	Hice	3 ☐ Suicide 6 ☐ Could not be	m, street, factory, office	28f. Location (Street		al Route Number,
5	tal or s afte al Dir ed in	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	ate)	7
/	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or		29a. Certifier (Check only 1	death occurred at the time, date and place, a	and due to the cause	e(s) and manner as	stated.
)	the hin 24 the F the F	Medical	one) and manner stated)			
	5 2 ₩	2	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month,	Day, Year)
			1 www ex	11 10251	7 M.	Ay 11	2007
-			30. Name and address of person who completed cause of death (Item 23a) (7	Cia	2.00	- DIAI
	Stat	e l	31. Date filed (Month, Day, Year) 32 Registrar's Signature	EMIN 10102125	OLEN	VURENI	2 41001
	Registra	-	MAY 1 3 2009 /	/			
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 4c per MD & 10b per FH G891 5/18/09 TT

State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 **Physician** DIEL DOROTHY 10 2009 4:45 a M /Medical Howard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health & Rehab Ellicott City Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 215–28–2019 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Min. Days 1 □ M 2 🖵 F Yrs. 5/16/1929 Baltimore, MD 79 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County Howard 10c. City, Town or Location 10d. Inside City Limits 10a. State i Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evaning must be notified at MD Ellicott City 1 ☐ Yes 2 X No Baltimore by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3004 North Ridge Road 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Louise Tiemeyer William Wallace Payant ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9522 Longview Drive - Ellicott City, MD 21043 Charles Piel -20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any injury or ot tsEsBurial 2 ☐ Cremation 3 ☐ Removal from State 5/13/2009 Lorraine Park Cem. Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling. Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Mortician 21. Signature of Funeral Service Libensee <u>-</u> License # M01537 1630 Edmondson Avenue - Catonsville Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Emphysema Cardio Vas Cular Difease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 ☐ Natural
2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐Yes 2 ☐ No death. investigation To the Funeral Director: completely filled in by the t 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30641 ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Neck Road Baltmore Maylu Sabapalhi Kamesh 2. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2009

			For	Sta	ate of Ma	aryland	/ Depa	rtment of I	Health and N	nental Hy	/giene		1 1 1
1 - State Registrar 1. Decedent's Name (First, Middle, Last)							Cei	tificate of	Death		Reg. No. 2	009	15411
			1. Decedent's Name (First, Midd)	e, Last)						2. Date of D Month		Year	3. Time of Death
	Physicia /Medic		G1yndon	A1be	rt	Duc	kwortl	1		May	11, Day	200 ^{Year}	8:20 P M
A V	Examin		4a. Facility Name (If not institutio	i, give street	and number)			4b. City, Town, o	or Location of Death		4c. Cou	inty of Death	
-			4905 Briarcli					Baltin		Lo Duta de		O Disth	lana (Stata ar Faraign
	Funeral Director		5. Social Security Number 228–14–4785	6. Sex 1 🖾 M 2		je (In yrs. la 84	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of B (Month, D June 2	irth 9a <i>y, Year)</i> 4, 1924	Cour	olace (State or Foreign otry) Maine
	p. ,		Usual Residence of Decedent			140. 00	T					1	0d. Inside City Limits
	arylar show	ŗ	10a. State 10b. County				Town or Lo					'	1⊠Yes 2□No
	he M	Director	Maryland			Ba1	timor	10f. Zip Code			10a Citizan	of What Cour	ntrv2
	a or 3	ᡖ	10e. Street and Number	ı. D 1	l=			212	220			SA	шу.
	eath is 23	Funeral	4905 Briarclif		las D <i>e</i> cedent	Ever in U.S.	13		Hispanic Origin? (Sp	necify Yes or N		Race - Americ	can Indian,
40	ter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	ried 1	rmed Forces?			f Yes, specify Cub	oan, M <i>e</i> xican, Puerto	Rican, etc.)		Black, White,	etc.
036	urs at	by	3 X Widowed 4 ☐ Divorced	lf.	Yes, Give ear or Dates:	WWI	I	l∐Yes 2⊠No	Specify:		Spi	ecify: Wn:	ite
2-0	72 hou	sted	15. Deceder (Specify only highe	t's Education	nnleted)		16a. Dece	lent's Usual Occu	pation during most of work	dina	16b. Kind o	of Business/In	dustry
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Model Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)		college (1-4or s	5+)	life.	DO NOT use retire aman	ed)		Ship	ping	
d 2	filed Hygi ther		17. Father's Name (First, Middle,	Last)					18. Mother's Nam	e (First, Middl			
Maryland	ld be lental ked o ic eve	To Be	Emery C. Duck						Marion 7	[. Brig	gs		
ary	shou and M s mar umat	۲	19a, Informant's Name/Relations	hip <i>(Type. P</i>	rint)		19b. Mailir	g Address (Stree	t and Number or Ru	ral Route Num	ber, City or To	wn, State, Zip	Code)
	1 and 2 Health a tem 27 is other tra		John Thomas W	olfe	Son-in	-Law	825 1	Vedgewood	d Road; Ba	altimor	e, MD	21229	
altimore,	es 1 a of He of He litem		20a. Method of Disposition	۰. 🗆 🗆		20b. Pla	ace of Dispo metery, crei	sition (Name of natory or other pla	ace)	Date	20c. Locati	ion - City or To	own, State
<u>Ĕ</u>	permit. Pages 1 Department of h Important: If ite any injury or ot once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		vai trom State		d1awn	Cemeter	y 5/1	5/2009	Wood1	awn, M	aryland
alt	permit. Departi Importi any inji		21. Signa ure of Funeral Service	Licensee	11/1	7	22	Name and Addr	ess of Facility Stoome of Car ndson Aver	erling,	Ashton	Schwa	b Witzke
Ω	90 F # 9	0 2	Mas	Kell	1/1/2	21		30 Edmoi	ndson Ave	consvil nue; Ca	tonsvi	lie, M	D 21228
			23a. Part 1. Enter the disease of shock, or heart failure. Lis	complication	ns that cause use on each li	d the death. ine.	Do not ent	er the mode of dy	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		Myo	cord	al =	Inforce	haw				Oliset and Death
	/Medical		resulting in death)	(· ·	Due to (or as								
	Examiner	_	Sequentially list conditions,	b									
	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2	Due to (or as	a consequ	ence of):						
18	xecut and I-tran	xan	that initiated events resulting in death) Last	c	Due to (or as	a conseque	ence of):						
,8760,	cate be executed physician and the burial-transit												
		edical		d		-							
Вох 6	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If	yes, outcome	of pregnar					23d	. Date of deliv	rery
ă	death e atte d for u	iciai	in the past 12 months?	4	Live birth			∃Ectopic pregnar ∃Other <i>(spe</i> c <i>ify)</i> .				Month	Day Year
P.O.	w requires that the de been signed by the should be detached	hys	9 Unknown	9	Unknown								
Α,	s that gned e det	by P	Part II. Other significant condition	ons contribu	ting to death b	out not resul	ting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Ď	quire en siç uld b	ed k	Hyperte	Weize						1 [Yes 2	No 3□ Pro	bably 4 Unknown
တ္ထ	aw re	plet	Consestin	e Hee	+ 60	ilure				24a. Wa	is an 2	24b. Were aut	opsy findings available ompletion of cause of
Vital Records,	The I	Completed								per 1 🗆 Yes	formed?	death?	2 No
ta	ian: rtifica	a)	25. Was case referred to medica	1					26. Place of Dea				
>	nysic nis ce direc	O B	examiner? 1 ☐ Yes 2 ☐ No	Hospit	tal: 1 ☐ Inpati	ient 2 🗆 E	ER/Outpatie	nt 3 🗆 DOA	ther: 4 🗌 Nursing H	ome 5 Re	sidence 6	Other (Spec	ify)
0	ng Pl fter t meral	ü	27. Manner of Death 1. ☑ Natural 5 ☐ Pendi		Ba. Date of Inj (Month, Da	ury a <i>y, Year)</i>	28b. Time o Injury	Wo	ork?	28d. Describ	e how injury o	ccurred	
0.0	endi eath. or: A the fu	cati	2 ☐ Accident invest	gation					□Yes 2□No				
Division of	l or Attendi after death. Director: A d in by the fu	Certification: T	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28	Be. Place of In building, e	jury - At hor tc. <i>(Specify</i>	me, farm, sti)	eet, factory, office		28f. Location City or 7	(Street and N own, State)	lumber or Rui	al Route Number,
Q	oital ours al		00- 0		T- # 1 1		dadaa 1	h	Almon aloka - 1 - 1		ha anus - (-)	- d	atatad
. 41	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifyi	Examiner:	n: To the best On the basis and manner s	of examinat	vie u ge, deat ion an d /or ir	n occurr ea at the vestigation, in my	time, date and place opinion, death occu	e, and due to the Irred at the tim	ne cause(s) ar e, date and pl	ace, an d due	to the cause(s)
101	To the within 2 To the соптрlе	Mec	29b. Signature and title of certific		and manner S	iaicu.		29c. Licer	nse number		29d. Date s	igned (Month	, Day, Year)
	⊢ ≯ F ŏ		M ==	//		MD		2	-777	7	M		2200

D0057237

May 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

+ 601 N. Ciroline St, Baltmore MI) 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) 32

State Registrar

MAY 13 2009

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MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2009 Month Year **Physician** EVA ELIZABETH **EVERING** 12 3:30 PM MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GLORIA FRIENDS HOME **ESSEX** BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F Months Days Hours Min. 215-40-5731 91 Director 8-21-1917 MARYLAND Usual Residence of Decedent 10b. County 10a. State 10d. Inside City Limits 10c. City. Town or Location show MD BALTIMORE th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examinar must be notified. Director MIDDLE RIVER 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 COWHIDE CIRCLE 21220 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: If Yes, Give Year or Dates: \$ Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES CHRISTOPHER KAHLER ELIZABETH JULIA (WENROTH) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 6103 CARDIFF AVE BALTIMORE, MD 21224 other! MICHAEL EVERING/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 5-16-2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME ROSEDALE, MD 21237 1211 CHESACO AVE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** rosclaratio 30 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes No. 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_4\,\square$ Nursing Home $_5\,\square$ Residence $_6$ XXDther (Specify) HOSPICE4 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of eath 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident s after dec. •al Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type

Registrar's Signature

NAEEM GAUHAR
31. Date filed (Month, Day, Year)

326

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland / Apparing of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 27, 19 Under 1 Year Birthplace (State or Foreign Country) **Funeral** Hours Months Days 220-22-2003 Maryland Director 1927 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show amorphint; if item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 USA 1801 Wentworth Pkwy Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No white Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sheet metal mechanic Md. Dry Dock 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Collins Charles Henry Fritsch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3023 Acton Road Baltimore, MD Myrtle Bischoff/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 MOther (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltiomore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septie Shock Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for a Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Whiknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physiclan; The within 24 hours after death.

To the Funeral Director; After this certificate t 2 N completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 A Yes 2 1 10 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient ၉ 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltomore, MD Loch Raven Blud

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 1 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4:00 AM M 05 09 2009 Dorothy M. Fleury /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Falls, Maryland
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
onths | Days | Hours | Min. | 8. Min. | Month, Day, Baltimore 11300 Raphel Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 □ M 2 🔀 F 87 06/08/1921 New York Director 219-10-4065 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examination at the natified at 1 □Yes 2 No Director MD Baltimore Upper Falls 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11300 Raphel Road 21156 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ∐Yes 2**X** No Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, in "no once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Catherine Weber Gerard Joseph Frederick မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Therese A. McDonald (daughter) 11310 Raphel Road - Upper Falls, Maryland 21156 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stephen Church Cem. 05/12/2009 Bradshaw, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses T. 11750 Belair Road - Kingsville, Maryland 21087 assa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Recurren /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed Atherosclerosis physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has t page 2 s autopsy performed? certificate 2 No 1 ☐ Yes 2 ☐ No 1 □Yes of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 4:25 PM MAL Alexander J. Feher 060, 2009 County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death laureDeGrace izens NUrsina ome 8. Date of Birth (Month, Day, Year)
September 3,1918 If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday Country) Pennsylvania Months Hours Min 90 216-09-2335 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🙀 No Md. Cecil Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1755 Principio Road 21911 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sparrows Pt. Ship Yard Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brigit Szena 01ek Feher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1755 Principio Rd. Rising Sun, Md. 21911 DTR. Carolyn A. Waltz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □Cremation 3 □Removal from State Parkwood 5-11.2009 Parkville, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) yournsion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) CHIMINA Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☑ Onknown 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 **√**No Other: 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Many of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 7/ 0

/Medical Examiner Examiner attending physician and for use as the burial-trar Physician/Medical signed by the atte þ Completed Be ို Certification: Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

this certificate has The

Physician

/Medical

Examiner

10a, State

Directo

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina.

Physician

death certificate be executed

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Records, law requires

or Vital

Division

Hospital or Attending Physician:

after death.

within 24 hours a To the Funeral I

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her

State Registrar

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

406

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Amend Item 21 per fh, g891,05/13/09dhb
Reg. No.
Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 2, 11:00 a^M 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care Homewood **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **X** M 2 □ F 01/27/1952 212-52-8288 57 Yrs MD Director Usual Residence of Decedent ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other thatmatic event, If a Medical Eventing must be notified at 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No MD **Baltimore Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21213 3467 Mayfield Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Specify: Black 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 □Yes 2 No Maryland 21215-0036 Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Operations SSA 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Baker L. V. Frieson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1223 Glenwood Avenue, Baltimore, MD 21239 William Frieson - Brother Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If itel any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/12/2009 Owings Mills, MD Garrison Forest Cemetery 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee Vaughn C. Greene per DVR 4905 York Road, Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) Physician FUCMO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23b. Was decedent pregnative past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death .9 ☑ Unknown 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Syed ir. F 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 2 12 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital 124 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 W. Mt. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

09-03709	
Anthony Griffin	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	•	icate of Death	Reg. No.
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of De Month May 8, 2	path 3. Time of Death Day Year 1454 bro
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs. 8. Date of I	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	218-11-2114 1 DM 2 DF	23 Yrs. Months Days Hours Min. Apri	16,1986 Maryland
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	10e, Street and Number	Baltimore 10f. Zip Code	10g. Citizen of What Country?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once. TO Be Committeed by Finneral Director	4504 Forestview Ave	21204	USA
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5-0036 lled within 72 hour Hygiene. lother than "natu the Medical Exar	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	Calvert Heating
ID 21215-0036 should be filed within 72 hours at and Mental Hygiene. 77 is marked other than "natural natic event, the Medical Examin To Be Committeed by	Anthony Orittin, Sr.	Renee 1	Nalone
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ω _ ≖ := .	20a. Method of Disposition 20b. Pla	ce of Disposition (Name of cemetery, matory or other place)	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If ite		Memorial PK 5/15/0° 22. Name and Address of Facility	Baltimore, MU
Derm Depa Impo	(new K. House St.	4600 Liberty Heights	Ave, Batto MD 21207
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Difailure. List only one cause on each line.		Approximate Interval Between Onset and Death
caminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):		
9	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
led nsit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
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760, icate be execuphysician and the burial - tra		ncy	23d. Date of delivery
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cords, P.O. B law requires that the d has been signed by the 2 should be detached an inferted by Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physi			Yes 2 ✓ No 3 Probably 4 Unknown
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f Vital Physician or this cert ral directo	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Fig. 1	R/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other:
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Division of Vital Records, P.O. Box 68760, To the Hospital or brystian: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - translanding Contribination: To Be Completed by Physician/Medical E-indical Contribination and completed by Physician Region E-indical E-indical Contribination and Completed by Physician/Medical E-indical Completed by Physician Region E-indical E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indical Completed by Physician E-indicated by Physician P-indicated by Physician P-indicat	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	or Town	n (Street and Number or Rural Route Number, City
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To the IIc within 24 To the Fu completely	one) 2 Medical Examiner:On the basis of examination and and manner stated. 29b. Signature and title of certifier	or investigation, in my opinion, death occurred at the time, d	ate and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	and	O.C.M.E.	May 9, 2009
	30. Name and address of person who completed cause of death (Item 2:	3a) 11 Penn Street, Baltimore, MD 21201	
Stat	23. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registra		parle .	
DHMH 17 Rev 1/2001	1	ORIĞINAL (DCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month AM DONALD AUBREY GRAY 4:55 2009 May /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**Д** М 2□ F Months 220-38-5842 Yrs. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov 1 Yes 2 No Director MD FREDERICK ALR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MILL BOTTOM RO USA 21771 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 ☑ No Specify: BLACK Specify. ģ 3 ☐ Widowed 4 Ø Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) GEN-STAR Elementary/Secondary (0-12) College (1-4or 5+) TRUCKING COMP. RUCK DRIVER TH 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES C -GRAS ALMEREITA ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau S BALTHORE MD 21244 DORKLLA L. JOHNSON (DAU) 3730 MILFORD MILL RD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11,2009 FAIRVION COM. 4 ☐ Donation 5 ☐ Other (Specify) FREDERICK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. KOLUNS FUN Home Thi Juy 2. 21701 FREDBRICK MO SOUTH ST 110 WOT 23a. Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cell Con Small **Physician** MON THS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No g

Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an 1 🗌 Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA rector: After this Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lead to be a second to be a s 29a. Certifier Medical (Check of one) and manner stated.

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To the within 2

State Registrar

29b. Signature

31. Date filed (Month, Day, Year)

tive of certifier

39 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

196 TJDLIVE, SUITE #225,

D006223

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY **Physician** 2009 12:10 P GENEVIEVE GRZYBOWSKI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2**X** F Maryland Director 213-12-2130 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or interesting to any or other traumatic event, it. "Modical Examination in this parallel." 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State Director 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 6735 Bessemer Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🖔 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No If Yes, Give Year or Dates: 2 Specify. 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home n/a (unknown) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Malinowski Antionia ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 bepartment of Health an Important: If item 27 Is any injury or other trauonce. 712 Kings Path, 3B, Bel Air, MD 21014 Henry Grzybowski - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Bayview Crematory 5-11-09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Solice 22. Name and Address of Facility Kaczorowski Funeral Home, 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** uks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed tal or Attending PhysIclan: The law rest after death.

Is after death.

In Director: After this certificate has be ed in by the funeral director, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day,

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MY 2. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MAY 1,00 AM 2009 Sutherlin Hundley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Nursing & Rehabilitation Montgomery Burtonsville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Nov. 17, 19061 M 2 F Virginia 102 Director 261-30-7688 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 1 ☐ Yes 2 ☑ No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 8811 Colesville Road Apt. 507 20910 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ģ White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) (Unknown) c 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Per.Rep.) Robert Coughlan 15220 Bitterroot Way Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Page Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCHEROTIC Immediate Cause (Final EREBROVASCUL ISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 PERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed STEO ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed and Division or Vital Records. P.O. Box 68760. attending physician signed by has funeral director, or Attending neral Director; / death. hours after within 24 hours at Hospital

Examiner

death with the Maryland

Baltimore, Maryland 21215-0036

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1 ASNEEM 31. Date filed (Month, Day, Year) Registrar

Medical

(Check only one)

29b. Signature and title of certifier

sueu

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

AVE suite en Baltoma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AICHAMI, 2835

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 8:23 a Charles M. Holmes Apr 29, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson **Baltimore Greater Baltimore Medical Center** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min. Maryland Director 218-44-5087 62 Dec 21, 1946 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 1X Yes 2 □ No **Baltimore** Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or idical Examiner must be r USA 21209 5729 Pimlico Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify **Black** ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Fire Fighter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Holmes Charles M. Harris 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4622 West Parker Road Oklahoma City, Ok 73127 Jarrett Holmes 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Catonsville, Maryland 05/04/09 4 Donation 5 Dother (Specify) Metro Crematory, Inc. 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** udencaranor disease or condition resulting in death) /Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 ☐ Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ arterial Line BCIQUIAN 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 s autopsy performe certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2**X** No 1 Inpatient ို 2 ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TEXTCErtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Texture In my opinion death account to the cause(s) and manner as stated Improve In my opinion death account to the cause(s) and manner as stated within 24 hours a 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00058082 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Sinte 550 mark Gosnell, mi 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 5, 2009 2334 М Jacqueline Kane Hilliard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore N/A Maryland General Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🔽 F Yrs Director Dec 25, 1951 Maryland 217-56-5525 57 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be redified at 1 Xes 2 No Director Baltimore Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 522 West Lanvale Street 21217 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐No Specify: Specify Black \$ 3 Widowed 4 Divorced Completed 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Franklin Square Hospital **Medical Aide** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Kane David Kane 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 West Lanvale Street Baltimore, Maryland 21217 Silas Hilliard item 27 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or c 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 05/18/09 Lansdowne, Maryland 4 Donation 5 Dother (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or wart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** therosc leesti Jear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a requires that the death certificate be executed Due to (or as a consequence of): earg attending physician and for use as the burial-trar resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown سمرح rias been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2/X No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 (No 1 □ Yes 2 X No 1 🗌 Yes Hospital or Attending Physician: funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗀 Innatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Magner of Death After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural death. 1 □Yes 2 □No after death 2 Accident 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar 29b. Signature and title of certifie

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Year)

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31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 21

R#gistrar's Signature

32.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29c. License number D32158

N. Eutaw St. Ste 407, Baltimore

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

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"natural", or items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or iten any Injury or other traumatic event, the Medical Examiner ane.

Baltimore, Maryland 21215-0036

Directo

Funeral

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death with the Maryland

The law requires that the death certificate be execute To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

	show, or heart failure. List only o	ne cause on each line.	Interval Betwee	n	
	Immediate Cause (Final disease or condition	Anoxic Brain Injury		ın	
	resulting in death)	Due to (or as a consequence of):	Mai Ulinea		
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23d. Date of delivery Month Day Yea	г		
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	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 5 / 6 / 0 9 28b. Time of Jojury at Work? Unknown 1 □ Yes 2 № No	28d. Describe how injury occurred Hanging		
Certification:	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Residence	28f. Location (Street and Number or Rural Route Number 482 ^{ity} N ^{Town} Partuxtent Rd Odenton, Md 21113	,	

Registrar

State

within 24 hours a To the Funeral L

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2009

NGENTON, Md 21113

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

19827

29d. Date signed (Month, Day, Year)

May 11, 2009

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND ITEM# IlperINF, G892, 673/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Sor 9 2009 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Koland are 17 more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □M 2 □ F 213-42-606 Director Yrs Mary b Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madeal Experiment must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ∏ Yes 2 □ No **Funeral Director** nam 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6924 20706 amor 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Armed 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Sever Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 😘 Specify ģ If Yes, Give Year or Dates: 51Q0 3 ☐ Widowed 4 🔀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) antham 20706 orraine. laylor-S 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 0 4 ☐ Donation 5 ☐ Other (Specify) In more 21. Signature of Euperal Service Licensee 22. Name and Address of Facility tome 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20794 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) S CVD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes \mathbf{a} 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No hours after death. d in by the f 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide vithin 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/12/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Woods Worther Noverall 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

			1 - For State Registrar	State of Mar	ryland /	-	tment of h		nd Mental F	lygiene Reg. No.	2009	15428
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	Funeral Director		5. Social Security Number 214-72-8266 Usual Residence of Decedent	IM 2DXF	(In yrs. last t		If Under 1 Year Months Days	Hours	Min. 8. Date of (Month, 6–26	Birth <i>Day, Year)</i> –1956	Co	thplace (State or Foreign ountry) RYLAND
	Maryland f show	or	10a. State 10b. County	f	10c. City, To							10d. Inside City Limits 1XYes 2 □ No
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21215-0036	d within 72 ho giene. er than "natur i the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) -12-	cation e co <i>mpleted)</i> College (1-4or 5+) -4-		(Give kii life. DC	nt's Usual Occup nd of work done O NOT use retired	during most o	J		nd of Business/	Industry OCIAL SERVICE
Maryland	should be filed withir and Mental Hygiene. s marked other than umatic event, the standard	To Be	17. Father's Name (First, Middle, Last) MILTON M. JOHNSON	I				18. Mother's	Name (First, Mide GINIA E.	dle, Maiden	Surname)	
	nd 2 allth all		19a. Informant's Name/Relationship (7)/19 TRUITT JOHNSON (BR	,	- 11	6902	BRIGHT			D BALT	IMORE,	Zip Code) 21207 MARYLAND
Baltimore,	permit. Pages 1 ar Department of Hee Important: If item any Injury or othe once.		20a. Method of Disposition 1XI Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Functial Service Ligense	آ بر	oemei VOODLA	tery, crema WN CE NER22. 1		5- ss of Facility	Date 15-2009 REDD FUNI	BALT ERAL S	ERVICÉ	MARYLAND
			23a. Part / Enter the disease, or compli- shoot, or heart failure. List only on	cations that caused the cause on each line.	ne death. Do			ng, such as ca	ardiac or respirator	y arrest,	E, MARY	Approximate Interval Between Onset and Death
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Division of	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, (Specify)	farm, stree		Yes 2⊡No	28f. Location	n (Street and Town, State)	d Number or Ru	ural Route Number,
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	To th within To th comp	Me	29b. Signature and title of certifier	Kotm	^	D	29c. Licens	e number		29d. Date	e signed (Monti	h, Day, Year) 2004
_			30. Name and address of person who con	mpleted cause of dear	th (Item 23a			AD R	AND KUS	TOWN	MARYL	TWD 21133
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's	Signature	ba	Mad					

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н	Physici	1. Decedent's Name (First, Middle, Last)					Month Day Year			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Death	AFRUL	4c. County of		
	Lxaiiii	CI	GIEN BURNIE HEALTH & KE	HAB	GLEN	BURNI	2	AA	\	
Г	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	7 Yrs.			June 21		Virginia	
	/land			y, Town or Loc	ation				10d. Inside City Limits	
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	or 28	Dire	10e. Street and Number		10f. Zip Code		1	I0g. Citizen of Wh	nat Country?	
	s 23a	eral	180 Inlet Drive	- T	2112			USA		
	ter de	Fune	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	S. 13. W	as Decedent of His Yes, specify Cuban	spanic Origin? (Sp , Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race Black,	- American Indian, White, etc.	
036	urs af al", or	by	3X Widowed 4 □ Divorced Year or Dates:	1	∐Yes 2 X No	Specify:		Specify:	white	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exantrac out the medified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupatind of work done du	tion uring most of work	ina	16b. Kind of Busi	iness/Industry	
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Maryland	ld be lental ked c ic eve	To Be	James Frank Robinson				ictoria			
ary	and Nand Second Second Second	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street a				itate, Zip Code)	
Σ.	and 2 lealth n 27		John Karl/son	1	Coventry					
Baltimore,	Pages 1 lent of H nt; If ite ry or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7 4 ☒ Donation 5 ☐ Other (Specify)	lace of Dispos emetery, crem	ition (Name of atory or other place)	Date	20c. Location - C	ity or Town, State	
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E.	Physician		Immediate Chuse (Final	1	+ F007		126		Interval Between Onset and Death	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the dred at the time, d	cause(s) and man date and place, ar	nner as stated. nd due to the cause(s)	
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			· Rechard /	MD	DOZ	519	1	MAY 5	2069	
			30. Name and address of person who completed cause of death (Item	1 23a) (Type, P	rint)	0 -	> '		10/1	
سين			31. Date filed (Month, Day, Year) 2. Registrar's Sign	ANDIC	MERS,	GLEN!	DURNI	E MI	21061	
	Sta Registra		31. Date filed (Month, Day, Year) 2. Registrar's Signal AV 1 3 2009	Havi						

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AMEND TITEM#7 per FH . G891 . 5/13/09 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 50 M 02X /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Maryord Med Honor Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Min. Hours 1 □ M Months Director 47-0 -0-05/06/2009 n/a MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examing Injury to other traumatic event, the Medical Examing Injury is a content once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 □Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5498 Langley Way 20032 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White/ Baltimore, Maryland 21215-0036 Specify: William Hispanic 1 XYes 2 □ No Specify: Completed by Mexican 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A Elementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kerber ဥ Chris Juanita Garcia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Kerber/Father 5498 Langley Way Washington 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 8 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pretern **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 📉 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed' 2 No 1 XYes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) 30. Name a nd address of perso no completed 22 Gree 31. Date filed Day, 32. Registrar's Signatu (Month, State MAY 1 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1:45 P 2009 May 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 909 Meadowbrook Rd Glen Burnie Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Birthplac Country) PA 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**A**)F /23 28 4822 Usual Residence of Decedent Months Days Hours Min. Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Eventinal mant be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2106 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 XXVo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: W ρ Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Membership Coordinator United States Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orval Clark Doris Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 Turnwood Dr, Glen Burnie, MD 21061 Sherrie Rae Werner Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖎 remation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify Bayview Crematory May 11, 2009 Baltimore, MD ur) of Funeral Service 22. Name and Address of Facility
Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 Gregory Fink M01148 23a. Part Enter the dishase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart life is 15 your cause on each line. Approximate Interval Between Onset and Death Immediate Tause (Fin Udisease or Indition resulting in distant) **Physician** DNCE /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of pate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Physician: The law requires that the death certificate be execute P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 23d Date of delivery 3 🗆 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ੬ 1 ☐ Yes 2 ☐ Yoo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 MNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1.7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and itle of cer 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Hanove,

South

300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 9:45 AM Dorothy Elizabeth Kuczinski 09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Dulaney Manor Care Nursing Home 8. Date of Birth (Month, Day, Yes January 26, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 5, 1932 Months Days 1 ☐ M 2 ₩ F 215-30-0743 77 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any ilury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County Baltimore Glen Arm 1 ☐Yes 2 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21057 USA 12804 Manor Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madeline Lind John A. Kuczinski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12804 Manor Road Glen Arm Maryland 21057 Anthony Armiger/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunial 2 □ Cremation 3 □ Removal from State St. Stanislaus Cemetery 5/12/09 Dundalk Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Newpeard Address of Tacility Inc. 5305 Hartord Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jas a disease or condition resulting in death) /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA P 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician To the Hospital or Attending Physician: this after death. within 24 hours a To the Funeral C

been signed by the attendin should be detached for use page 2 s completely filled in by the

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

2009

29c. License number H0054424 29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harmonds lane #LZ Brooklin, MD 21225 Cyrus Asadi 606 32. Registrar's 9ignature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Y**e** ar Anthony George Kurgan 10:18AM MAY 2009 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Ye AUGUST 31, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Year) 1924 218-14-6827 Months Days Hours Min 1 ☑ M 2 ☐ F 84 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits N/A Maryland Baltimore 1 Yes 2 □ No 10f. Zip Code 21214 10e. Street and Number 6305 Fair Oaks Avenue 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 DaYes 2 □ No WWII 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XXNo Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Machinist mechanic **Mechanics** Elementary Secondary (0-12) Conege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franciszek Kurgan Maryanna Krawczyk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Kurgan/Wife 6305 Fair Oaks Avenue Baltimore Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 5/14/09 Dundalk Maryland 21. Signature of Funeral Service Licenses 2. Nama and Address of Facility 1. S305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY Due to (or as a consequence of): CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) SEPSIS Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEVERE METABOLIC ACIDOSIS 4 Unknown dings available n of cause of

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Municipal Events.

/Medical

10a. State

Director

Funeral

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Completed

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sician and burial-trans attending physician for use as the buria for the detached signed to page 2 should been has certificate After this

the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician:

Hospital or Attending

death.

24 hours after

the

in by

filled

Medical

Funeral Director:

the

2

Examiner Physician/Medical ģ Completed Be Certification: To funeral

in the past 12 months? ☐Yes 2☐No 9 Unknown

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 ∐ Yes 21	No 3∐ Probably 4
24a. Was an	24b. Were autopsy find
autopsy	prior to completion
performed?	death?
1 □ Yes 2 No	1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of cortifier 29c. License number D24034

1 Inpatient

(Month, Dav. Year)

28a. Date of Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 76171 051 22. Registrar's Signature TOWSON MARYLAND 21204

28b. Time of

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland /	-	tment of H ficate of L			jiene _{eg. No.} 2	009	15434
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joellen Knight		-		2. Date of Dear Month	th Day	Year	3. Time of Death
*	Examin		4a. Facility Name (If not institution, give street and number) University of Maryland medial	center	Balt	Location of Death			unty of Death	n' N/A
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 □ F 218-70-5031 Usual Residence of Decedent		f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year)	Cou	hplace (State or Foreign untry) Maryland
	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, It I footer Ers. it we must be collined at	ctor	10a. State 10b. County 10c. City, Tow Maryland N/A	wn or Locati		altimore				10d. Inside City Limits 1 1 Yes 2 No
	vith the	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen	of What Cou	·
	eath v	Funeral	902 Pennsylvania Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	13 Was	s Decedent of Hi	21201 spanic Origin? (Sr	pecify Ves or No-	14	U.S Race - Amer	
920	urs after d al", or iten	by	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		es, spedfy Cuba]Yes 2☐No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White ecify:	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentral Hygiene. If the 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, It. Modical Eventing a minimal to notified a	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind	nt's Usual Occupa d of work done d NOT use retired,	uring most of work	ding	16b. Kind	of Business/I	
2	ed with	Con	12		Hom	emaker				Home
Maryland	should be file and Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) Kenneth Knight			18. Mother's Nam		Maiden Sur e Mae K		
Mar	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)		· ·	and Number or Ru				
	1 and Health em 27 ether t	1	Gloria Knight 20a. Method of Disposition 20b. Place of Disposition			nia Avenue #			ion - City or 1	
בו ה	Pages nent of int: If ite iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		on (Name of ory or other place	_ į	05/18/09		•	e, Maryland
	permit. Pages Department of I Important: If ite any injury or of	П	21. Signature of Funeral Service Licensee		ion Cemete lame and Addres		03/10/09	La	IISGOWIIC	s, Maryland
m	an m	t ta	23a. Part1, Enter the disease, or complications that paused the death. Do	9.	Estep B	rothers Fune	ral Service,	P. A.		
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O. Box 68	attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							ivery Day Year
Vital Records, P.	w requires that the designed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting	in the unde	erlying cause give	en in Part I.		bacco use es 2□N		the cause of death?
ဝ၁	has bee	Completed	Pulmonary Hypertension				24a. Was a		4b. Were au	topsy findings available completion of cause of
ř ;	ate h	Som	Coronary artery disease				autops perform 1 □Yes	med? 2 XNo	death? 1 ☐ Yes	1/
VITA	certific ector,	Be	25. Was case referred to edical examiner?		Othe	26. Place of Dea				
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o O	th. : Afte e fune	tlon		Injury	28c. Injury Work M 1 🗆	? res 2 □ No	200. Describe in	ow injury or	,curred	
DIVISION	a after dea	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fi building, etc. (Specify)	arm, street,	, factory, office		28f. Location (S City or Town	treet and N n, State)	lumber or Ru	ıral Route Number,
411000	to the negotian or training ringstrain. The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death oo and/or inves	ccurred at the tin stigation, in my o	ne, date and place pinion, death occu	r, and due to the or rred at the time, o	cause(s) an	id manner as ace, and due	s stated. to the cause(s)
,	To the confined with	×	29b. Signature and title of certifier **MD** **MD** **AD**	29c. License	7 4 9 8 8	2	9d. Date s	igned (Month	h, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a)		Stree 1	74988 + Bal	tmore	M	0 2	1201
	Sta		31. Date filed (Month) Day, Year) 3. Registrar's Signature	park						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Month Anna Catherine Kutzleb-Schultz рм 2009 May 10 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore** Edenwald. Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Director 216-46-6509 102 Oct 9, 1906 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 800 Southerly Rd. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 🛛 No Specify Specify:White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 should be filed w h and Mental Hygie ' is marked other th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward McMahon Francis Marv Shannon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 S. Buckley Circle Aurora, Co. 80017 <u> Mr.Michael Kutzleb/ Grandson</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 5-13-09 Pikesville, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fund al Service Lice 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complication of hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Pect Denentic Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown O Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 □ No Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To Nursing Home 5 Residence 6 Other (Specify) o funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐Yes 2 ☐ No after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUCKENSMITH CMP

32. Registrar's Signature

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State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** 2009 3:30p Bertha Little /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1050 East 33rd. Street Apt#210 Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 XF 216-20-9551 9-23-1927 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Evaruiner must be notified at 1 X Yes 2 □ No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1050 east 33rd Street Apt. 210 "natural", or items 23a 21218 Funeral ŬSA. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Eventual any injury or other traumatic event, the Medical Eventual any injury or other traumatic event, the Medical Eventual any injury or other traumatic event, the Medical Eventual and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and th 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Completed by Specify: African-American 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elevator Operator Bragers Gutman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Clark Important: If item 27 is marker any injury or other traumatic once. ဂ Gertrude Cager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin F. Clark/ Grandson 41 Saddiestone Court, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 5-12-09 Woodlawn, MD 22. Name and Address of Facility $Wylie\ Funeral\ Home\ P.A.$ 21. Signal re of Funeral Service Licenses 9200 Liberty Road Randallstown, MD 21133 23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 15 chemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infiltedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> tXYes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 ☑ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

Little

Bertha

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Registrar's Signatu

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Irene Lindsev 1:35F M MAY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M X/□ F 247-52-3790 73 Director 10-3-1935 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be netified at once. Director 1 X Yes 2 ☐ No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1204 N. Dukeland Street 21216 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∑No Specify. Specify: African-American 至 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homenaker Damestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Shell Sr. ပ Tessie Austin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Tyson/ Daughter 3909 Amy Lane, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veterans 5-15-09 Crownsville, MD 4 ☐ Denation 5 ☐ Other (Specify) of Funeral Service Licens 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. Vanta Cu 9200 LibertyRoad, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIAC THROMBOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VENTRICULAR FIBRILLATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit be exect Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mon 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. ed by the a 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DISEASE CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform Division of Vital 1 □Yes 2 NO 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZNo Inpatient မ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending within 24 hours after death.

To the Funeral Director: # 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature an 29c. License number title of certifier 29d. Date signed (Month, Day, Year) D34737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS D. JOSEP OSLER DRIVE TOWSON, MARYLAND 21204 7601

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVRstate of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 16 2009 Year **Physician** 11:50A M Stanley Mortimer Levy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3122 Gracefield Rd. #620 Silver Spring Montgomery 8. Date of Birth (Month, Day, Mar 25, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Months Days 1 ☑ M 2 □ F 90 1919 Director 317-01-3382 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20904 3122 Gracefield Road #620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [ĀVes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other fraumatic event. The Market and 100c. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12attorney legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Levy Anna Farrar ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3122 Gracefield Road #620 Silver Spring, MD 20904 Harriett Levy/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Ranald Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 weeks Dissecting thoracic aortic sneurysm /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence officause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Be Certification: To

law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a d be detached f page 2 should peen has Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate h funeral (filled in by the 24 hours a completely To the I within 2

death with the Maryland

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23a

or items

				performed? 1 □ Yes 2 □ No	death? 1 Yes 2 No						
25. Was case referred to medic	al	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify)									
Z Accident	tigation	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury oc	curred						
3 ☐ Suicide 6 ☐ Could deter	a not be mined 28e. Place of Injury building, etc. (- At home, farm, street, fact Specify)	ory, office	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,						
	ing Physician: To the best of r										

29b. Signature and title

29c. License number 29d. Date signed (Month, Day, Year)

MD 20737

D 24093

Riverdale

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5711 Sarviş Ave Mark A. Parkhurst

and manner stated

31. Date filed (Month, Day, Year) 32. Registrar's Sinature MAY 1 3 2009

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State at Mary 1909 1090201120110 at Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** aFavors 05 08 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner NorthWest andallstown Baltimone. HOSpice 5. Social Security Number unk 6. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Evantings must be notified at Baltimore MD Windsor Mill 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country MayHeld "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 2th orade Data Analysis Fraessing Supervisor Manland Noars 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. La Favors Wille Mary Neeley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Lawnwood Circle Gwynn Oak, MD 21207)llanı Latavors 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Woodlawn Cemetery Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Greene Funeral SVCS berty Road Kandall Stown MD 23a. Part 1. Ent f the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0 Se 200 a /Medical y, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MARIS lim TIMORE 24 Hrs. Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show injury or other traumatic event, the Medical Evan in an unstitue multipled at 1 Nes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō erne 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White etc Never Married 2 ☐ Married 2 No 21215-0036 1 ☐ Yes Specify: 2 Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than ' Elementary/Şecondaşly (0-12) College (1-4or 5+) Hygiene. Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ma 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 i 9up ma 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Pages 1 Burial 2 Cremation 4 □ Donation ∫ Other (Specify) 21. Signature of meral Service Litens 'n Approximate Interval Between Onset and Death 23a. Part 1. Ence the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) 1 □Yes 2 □No Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate l 1 ☐ Yes 2 No Division of Vital 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify HSSPICE Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. KINGESE 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number 30. Name and add son who completed cause of death (Item 23a) (Type, Print) DULANCY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State of Maryland	/ Depa		of H	ealth a		-	/giene	•	15442
	Physic	ion	1. Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
	/Medi		THOMAS L. MARTIN, JR.						MAY	8		7:00 A M
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, To			f Death		40	. County of Death	n
1			505 S. UNBRA STREET 5. Social Security Number 6. Sex 7. Age (In yrs. las	A b ladb alon ()	BA. If Under 1	LTIM	IORE If Under 2	DA Hre	9 Date of Bi	uth	N/A	anlaga (Ctata a v Fauri
	Funeral Director		5. Social Security Number 219−18−6530	Yrs.		Days	Hours	Min	8. Date of Bi (Month, D MARCH	14,	1924	nplace (State or Foreign untry) MD •
	yland now		10a. State 10b. County 10c. City,	Town or Lo	cation				-			10d. Inside City Limits
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	ours after death with the Marylan al", or items 23a or 28a-f show Examinat must be notified at	Director	10e. Street and Number		10f. Zip C	ode				10g. Ci	itizen of What Cou	untry?
	ath w	la	505 S. UMBRA STREET					1224			TED STAT	ES
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Deceder f Yes, specify	nt of His y Cuban	spanic Orig n, Mexican,	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	0-	 Race - Amer Black, White 	
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2	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Evening roust by notified at	Completed	11 0		PAII	NTER	ξ				GENERAL	MOTORS
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Maryland	S = =		19a. Informant's Name/Relationship (Type. Print) THOMAS L. MARTIN/NEPHEW		_						or Town, State, Z MARYLA	• •
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B	permi Depa Impol any ir		Al trips									ND 21224
			23a. Part 1. Enter the disease, or complications that caused the death shoot, or hear at the List only one cause on each line.	Do not ente	er the mode	of dying	, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between
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	/Medical	Ш	resulting in death) Due to (or as a cors a puer	nce of):	11.70		. 1					
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89	tificat ig phy as the	edic	U					000				
Box 68	th cer endin	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pre	annnau					23d. Date of deli	very
Э.	s deat he att ed for	sicis	1 Yes 2 No 4 Pregnant at time of dea		Other (spec						Month	Day Year
P.O.	nat the d by t etach	Phy	9 LI ONKNOWN	a a la Mara con			- in Donal		nna Did	4-4		Ab 2
ds,	Attending Physician: The law requires that the death certificate be executed refeath. exteath. ector: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ð	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cau	se giver	ın Part I.		100	20		the cause of death?
Ö	requ	etec				-			_ X	-		
Division of Vital Records,	ne law s has ge 2 s	Completed				-			24a. Was		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
[a]	in; Th ificate or, pay		25. Was case referred to medical						_ 1 □ Yes	2 X N	o 1 ☐Yes	2 □ No
>	/sicia s cert lirecto	o Be	examiner? 1 Yes 2 No	2/Outnation	+ 3 🗀 DOA	Other			(Check only		6 □Other (Spec	
jo l	g Phy ter thi	Ė.	27. Manner of Death 28a. Date of Injury 28	Bb. Time of Injury		Injury Work?	at		28d. Describe			my)
Ö.	Attendin death. ctor: Af y the fur	atio	2 ☐ Accident investigation	injury	М		es 2□N	lo l				
ivis	rrAtter de irecto	ţį.	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, o	office		- 2	28f. Location ((Street a	nd Number or Ru e)	ral Route Number,
Ω	ntal ors af	2	* /						•		,	
7	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	n occurred at vestigation, ir	the time my op	e, date and inion, deat	d place, h occurr	and due to the ed at the time	e cause(: , date an	s) and manner as id place, and due	stated. to the cause(s)
U	vithin To the comp	Me	29b. Signature and title of certifier		29c. L	icense	number			29d. Da	ate signed (Month	, Day, Year)
) south ful	es	Do	OC	24	30	3	5	18/20	07
	1871		30. Name and address of person who completed cause of death (Item 23	3a) (Type, F			1-			λ	, n	HNA
	10		31. Date filed (Monith, Day, Year) 32. Registrar's Signatur	10	350	7		9,5	EVI	7	191	IN KU
	Sta Registr		31. Date filed (Month, Day, Year) NAY 1 3 2009 Server 32. Registrary Signature 32. Registrary Signature	ale								+214

DHMH 17 Rev 1/2001

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		for State Registrar	State of M	larylan		artment o			fental Hy	/giene Reg. No2	09	15443
	Physician	1. Decedent's Name (First, Middle,							2. Date of Do	eath Dav	Year	3. Time of Death
2	/Medical	Edna Mae Brown							05-07-			300 P M
	Examiner	4a. Facility Name (If not institution,		r)		4b. City, Tow		n of Death			ty of Death	
	Funeral			ge (In yrs. I	ast birthday)	Be1 If Under 1 Ye	ear If Und	ler 24 Hrs.	8. Date of Bi	irth	rford 9. Birthp	place (State or Foreign
	Director	238-12-3045	1 ☐ M 2 💢 F	92	Yrs.	Months Da	ays Hour	s Min.	11-25-	-1916	Coui	NC NC
	P ,	Usual Residence of Decedent		T								
	arylar show	10a. State 10b. County			, Town or Lo						'	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	vith the Mar or 28a-f st be notified Director	TN Johns	on 	Mo	untair	1 City	1.			10g. Citizen o	f lath at Cause	
05	with the Maryland a or 28a-f show the mutthed at	10e. Street and Number 263 Oak Street					683		:	USA		iu y :
85	r items 23a	11. Marital Status	12. Was Decedent	t Ever in U.S	S. 13. V			Origin? (Sp	ecify Yes or N		ace - Americ	can Indian.
m 980		1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces	?		Was Decedent fYes, specify 0 I∐Yes 2 🛛			Rican, etc.)		ack, White, hify: Whit	etc.
5-003	ed within 72 hours a ygiene. For than "natural", of the Model Exam t, It o Model Exam Completed by	15. Decedent's (Specify only highest	Education	- 7	(Give	dent's Usual Or kind of work do	one durina m	ast of work	ina	16b. Kind of	Business/In	dustry
215	ithin and "ne."	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use re	etired)	OSCOT WORK	ng.		a .	
12	Hed w Hygiel Her th	12			Owner	•	40.44	Abada Nasa	/First Middle	Dept. e, Maiden Surna		ž
2009 Maryland	ontal Hed out	17. Father's Name (First, Middle, L. Mastin Clyde	Brown						a Blac		arre)	
2009 e, Maryla	thould Ind Men marke matic	19a. Informant's Name/Relationshi			19h Mailin	na Address (St				ber, City or Tow	n State Zir	Code)
2 €	nd 2 s alth ar 27 is r trau		aughter)			•				MD 210		
عر ore,	s 1 au of Hea item	20a. Method of Disposition		20b. P		sition (Name o			Date	20c. Location		wn, State
- E	Page nent c int: If	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		<i>;</i>		em. Par		05-12	-2009	Mouna	tin Ci	ity, TN
5 7 <u>5</u> 1 <u>7</u> 1 <u>5</u> 1 1 <u>5</u> 1 1 1 1 1 1 1 1 1	rmit. spartn porta y Inju	21. Signature of Funerat Service Li	censee					cility Sch	imunek			ofBel Air
2 =	82 = 9	LAGT.	eles .							el Air,		
A		23a. Pa 14 Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each	ed the death line.	. Do not ente	er the mode of	dying, such	as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician	Immediate Cause (Final disease or condition resulting in death)	_a. neci	ne	A pu	enen	~eL					Onset and Death
	/Medical Examiner	resulting in death)	Due to (or as									
ال		Sequentially list conditions,	b Due to (or as	s a consequ	ence of):							
lu 1	executed an and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,							
7.0	be executed sician and burial-transit al Examin	resulting in death) Last	Due to (or as	s a consequ	ence of):							
154 8760,	hysici the bu		d									
~ °	Physician: The law requires that the death certificate be executed ribis certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit: To Be Completed by Physician/Medical Examir	IF FEMALE:										
Box >	attenc for us	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal	death 3	Ectopic pregr				l l	ate of delive Month	ery Day Year
20	signed by the signed by the signed by the signed by the signed by the signes by the signes by the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the signes of the si	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown		eaun 5∟	Other (specif	y)					
RROWN scords, P.C	that ned b deta	Part II. Other significant condition	s contributing to death	but not resu	Iting in the ur	nderlying cause	given in Pa	rt I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
S 5	quires t an signe uld be o	CVA							1 🗆	Yes 2 □ No	3□ Prot	bably 🍋 Unknown
Records,	: The law require cate has been si page 2 should b								24a. Was		o. Were auto	ppsy findings available
	The I								auto perf 1 □ Yes	formed? 2 No	death?	ampletion of cause of
MAE of Vital	sician: The la certificate ha rector, page 2	25. Was case referred to medical examiner?					26. Pla	ace of Deat	h (Check only	one)		
\$ 5	this call dire	1 Tes 2 No			ER/Outpatien			Nursing Ho				Daughter's WResidence
_	ling F After funera	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D	jury l <i>ay, Year)</i>	28b. Time of Injury	'	Injury at Work?		28d. Describe	how injury occi	urred	
Z isi	death death stor: / the	2 Accident investiga 3 Suicide 6 Could no	t be	niury - At ho	me farm stre		1 ☐ Yes 2		28f Location	(Street and Nur	nhar ar Pur	al Route Number,
EDNA Division	tal or Attending Phys rs after death. ral Director: After this led in by the funeral dir Certification: To	4 ☐ Homicide determin	building, e	tc. (Specify	()	set, lactory, on			City or To	own, State)	nber or Hurs	ii noute Namber,
20	To the Hospital or Attending Physicis within 24 hours after death. To the Funeral Director: After this cer completely filled in by the funeral direct managed of the funeral direct Medical Certification: To B	29a. Certifier (Check only one) Certifying	Physician: To the best xaminer: On the basis and manner s	of examinat	wledge, death tion and/or in	n occurred at the vestigation, in I	ne time, date my opinion, d	and place, death occur	and due to the red at the time	e cause(s) and e, date and place	manner as s e, and due to	stated. the cause(s)
0	To th To th comp	29b. Signature and title of certifier					ense numbe			29d. Date sign	ned (Month,	Day, Year)
		Dans "	50			9	322	75		man -	8 200	25
		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type, I	,			0 0	Λ		
		31. Date filed (Month, Day, Year)	32-Regist	UNS trar's Signat	W.	Mack	har	1 les	Bel	Air M	ID 8	21014
	State Registrar	MAY 1 3 20	19	ar a digital	han	Las						

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			1 - State of Maryland / De Registrar	partment of Health a ertificate of Death			ene	9 15444
	Dhyaisi		1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Yea	3. Time of Death
	Physici: /Medic		Aubrey Wallace Meredith			May 5,20	009	4:20P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of			4c. County of De	
a grafe ²	F		11207 Baker Avenue 5. Social Security Number 6. Şex 7. Age (In yrs. last birthdu	White Marsh		8 Date of Birth	9 F	Balto.
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdom) 7. Age (In yrs. last birthdom) 7. Age (In yrs. last birthdom) 7. Age (In yrs. last birthdom) 7. Age (In yrs. last birthdom) 8. Sex 9.	Months Days Hours	Min.	8. Date of Birth (Month, Day, August 8	Year) 3.1939 We	Country) st Virginia
	pu ,		Usual Residence of Decedent					
	aryla shov	o.	10a. State 10b. County 10c. City, Town or					10d. Inside City Limits 1 □ Yes 2X No
	the M	Director	Md. Balto.	White Marsh		10	g. Citizen of What	
	3a or	Ĭ D	11207 Baker Avenue	21162			USA	Southly.
	death	Funeral [Was Decedent of Hispanic Oriell If Yes, specify Cuban, Mexican	igin? (Spe	ecify Yes or No-	14. Race - Ar	merican Indian,
36	filed within 72 hours after death with the Maryland Hygione. Hygione. Hygione read and a show and the inciting and the show and, the Mcdont Exactions and the inciting at	by Fu	1 Never Married 2 Married 1 Tayes 2 No 1957-1960	1 ☐Yes Ž☐No Specify:		HICAN, etc.)	Black, Wh	wite, etc. White
215-0036	2 hour		15. Decedent's Education 16a. De	cedent's Usual Occupation			6b. Kind of Busines	ss/Industry
2 2 2	nin 72 3. 3n "ne Medie	plet		ve kind of work done during most b. DO NOT use retired)	t of worki	ng		
7	ygiene /giene er tha	Completed		t Manager		M	lanufactu	ring Co.
Baltimore, Maryland	ss 1 and 2 should be filed v of Health and Mental Hygic f item 27 is marked other: r other traumatic event, II	Be	17. Father's Name (First, Middle, Last)			(First, Middle, M	aiden Surname)	
<u>\S</u>	should be f and Mental I s marked ol tumatic ever	မ	Aubrey J. Meredith			allace		
<u>8</u>	d2sh Ithan 27 isr traun			ailing Address (Street and Number			-	
<u>ი</u>	t Health Health Item 27 other tr		20a. Method of Disposition 20b. Place of Dis	07 Baker Avenue			Oc. Location - City	
Ë	Pages lent o nt; If i		1 IBurial 2 ICremation 3 IBemoval from State	rematory or other place) Hills 5	5-9-2	009 M	iddle Ri	zer. Md.
ä	permit. Pages 1 an Department of Hea Important: If item 2 any injury or other once.		21. Signature of Funcial Service Licensee	22. Name and Address of Facility			Funeral	
מ	permi Depa Impo any ir		If the	9705 Belair R	Rd. N	ottingha	m, Md. 2	1236
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as	cardiac c	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. End Stage Metas	static Colon Car	ncer			Onset and Death yr
	/Medical Examiner		resulting in death) Due to (or as a consequence of):					
		e.	Sequentially list conditions, if any leading to immediate b. Cirrhosis Due to (or as a consequence of):	Non-Alcohol				yrs
	uted d ansit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					yrs
o Î	e exec an an rial-tr		resulting in death) Last Due to (or as a consequence of):					
09/89	certificate be executed rding physician and see as the burial-transit	edical	d. <u>Diabetes Type</u>	<u>II</u>				yrs
×	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med		3 □ Ectopic pregnancy 5 □ Other (specify)			23d. Date of o	delivery Day Year
ري ح	s that med b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		23e. Did toba	acco use contribute	to the cause of death?
ecoras,	equire en sig ould b		Cachecxic, Severe Malnutrition			1 ☐ Yes	s 2 🔀 No 3 🗌	Probably 4 ☐ Unknown
S S S	To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director, After this certificate has been si completely filled in by the funeral director, page 2 should I	Completed	Hyperlipidemia, Anemia, Atrial Fibr	illation		24a. Was an autopsy perform	prior t	autopsy findings available o completion of cause of
VITAL	n: Th fficate or, pag		Renal Insufficiency, Coronary Arter			1 □Yes 2	Mo 1 □Y	es 2 🗷 No
5	rsicla s cert lirecto	Be c	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpar			(Check only one) nce 6 □Other <i>(S_i</i>	
	g Phy ter this teral o	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		28d. Describe how		pecity)
vision	endin ath. or: Af	atio	2 Accident investigation	y Work? M 1 □Yes 2 □t	No			
<u> </u>	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	2	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
_	pital ours a eral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date ar	nd place	and due to the co	uso(s) and manner	no stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, dea	ath occurr	ed at the time, da	te and place, and d	ue to the cause(s)
	Vith To th	N	29b. Signator and the objectifier Reilly M	29c. License number	49	9 11	Date signed (Mo	7.009
			30. Name and addless of person who completed cause of death (IJem 23a) (Typ	e, Print) Crossroads	13	Altims	re Ma	21778
J	Sta	e	31. Date filed (Month, Daf, Year) 32. Registrar's Signature	0102310447	, ,,,,		-100	-1-20
	Registra		MAY 1 3 2009 Sevent S. Jan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** P^{M} Zaferios Ν. Mitsos 2009 5:00 May 0. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Towson
If Under 1 Year | If Under 24 Hrs. | Min. <u>Baltimore</u> Greater Baltimore Medical Center 8. Date of Birth (Month, Day, Year) Feb 10, 19 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Months Days Hours 1 X M 2 □ F 021-18-8949 90 1919 Greece Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 🔀 No Director Baltimore Towson Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21286 3 Southerly Court Unit 405 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. IXYes 2 □ No fYes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 👿 No <u>م</u> Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Food Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kyriaki Theodosiou Nicholas Mitsos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown, Md. 21136 Mr. John Mitsos/ Son 3922 Log Trail Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem. 5-14-09 Woodlawn, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lig 1050 York Rd. Towson, Md. 21204 in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the distase, or cashock, or heart fail re. List or Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injur that initiated events resulting in death) Last vascular disease as a consequence of) Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 INO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Physician; The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760. the use as After this certificate

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Ever-inst must be notified at once.

Physician

/Medical

Examiner

timore,

or Attending nours after death.

neral Director; //
filled in by the fu within 24 hours a Hospital

6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who con

eath (Item 23a) (Type, Print) 32. Registrar's Signature

noleted caus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural" --- any injury or other traumatic excess.

Physician /Medical Examiner

The law requires that the death certificate be executed for use as the burial-tran certificate has been signed by the attending physicien rector, page 2 should be detached for use as the burial or Attending Physician: funeral director, After this death. 24 hours after death Funeral Director: filled in by

Division or Vital Records, P.O. Box 68760,

2. Date of Death 3. Time of Death Day Month Joyce L. Brockington Nowlin 0343 a^M 2009 May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/ABaltimore Harbor Hospital Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7-7-1942 9. Birthplace (State or Foreign Country)
MD 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F 66 Yrs 217-46-4543 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 🏖 ☐ No **Funeral Director** Patapsco Park MD A.A. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21225 222 Berlin Ave 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Brockington Arthur Brockington 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3615 Sylvan Dr. Balto. MD 21207 Leroy Nowlin Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville Veteran5-13-09 Crownsville MD 21. Signature of Foreral Service License 22. Name and Address of Facility Estep Bros. Funeral Serv. 1300 Euatw Place Balto. MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a conse IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 2 DER/Outpatient 3 DOA 1 Yes Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: 10 the basis of each manner state Certifying Physician: To the best of ny/knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and Month Day, Year) 30. Name and State

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Registrar

the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** DRWIG 2:10 2009 MARIE 05 10 /Medical 4a. Facility Name (If not institution, give street and number) To has 4c. County of Death City. Town, or Location of Death Examiner Hopkins Bayview Care Contar-LAMPunit BALTEMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Funeral Months Days Hours 1 □ M 2 X F MARYLAND Director 212-26-9711 Usual Residence of Decedent 10d. Inside City Limits Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "hocizal Evantment rust be notified at opice. 10a State 10h County 10c City Town or Location Funeral Director 1 ☐ Yes 2√∑ No BALTIMORE ROSEDALE MD the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. 21237 U.S.A. 8002 DUVALL AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HARRY COHEN Elementary/Secondary (0-12) 1 2 College (1-4or 5+) ADMINISTRATIVE ASSISTANT INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH IMPALLARIA ANNA (BIANCA) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 DUVALL AVENUE 21237 RICHARD J. ORWIG/HUSBAND ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 5-14-2009 TIMONIUM, MD 4 □ Donation 5 ₩ Other (Specify) FNIOMEMENT DULANEY VALLEY MEMORTAL 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ISTIVE heart CONG /Medical Due to (or as a consequence of): Examiner Cardiony hem. 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sone-quence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal innertal innertal complete in the Windia-Iransit Due to (or as a consequence of): and kiry Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No diabete 24a. Was an 1 □ Yes 2 □ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 5505 Hooving 31. Date filed (Month, Day, Year) MAY 132

31. Date filed (Month)

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hmore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05/10/

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:00p M 10, 2009 MAY WYLIE B. PAYTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE 2136 WALBROOK AVE. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Days Months 1 XM 2 □ F VIRGINIA 10-14-1924 Director 84 212**–**20–4368 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shore Examiner must be notified at 1 X Yes 2 No BALTIMORE MD. N/ADirector 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21217 2136 WALBROOK AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: hours after 1 ☐ Never Married 2 X Married 2 XN0 Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: BLACK "natural", or Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than DRIVER -9-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be find and Mental Find marked of ANNIE SMITH t and 2 should be Health and Ment tem 27 is marked JOHN D. PAYTON ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2136 WALBROOK AVE. BALTIMORE, MARYLAND 21217 ROBIN PAYTON-PARKER (DAUGHTER) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation KING MEMORIAL PARK 5-15-2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) D. HIBNER2. Name and Address of FacilityPHILLIPS FUNERAL SERVICE 21. Signature of Funeral ervice 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shi of or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease condition Prostate **Physician** disease condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): physician at the burial Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a d be detached fo 1 □Yes 2 □ No. P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 V No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No NEWFIA 1 ☐ Yes 2 🖫 No certificate of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death .cal or At.
Cours after dean.
'9| Director: At.
in by the fire 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MS FACE

29d. Date signed (Month, Day, Year)

State Registrar

29a. Certifier (Check only

31. Date filed (Month)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601

Hospital

Lock Kaven

2. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

25391

29d. Date signed (Month, Day, Year)

Blud Baltimore Mp 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me,g891,05/17/09dhb, 23a
trar

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** RAY GWENDOLYN 03:58 Affeil 2009 08

/Medical Examiner

Funeral Director

death with the Maryland show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Myddal Exprised to 1 and the north of once.

Maryland 21215-0036

Baltimore,

Physician /Medical Examiner

ner

Exami

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Medical

29a. Certifier (Check only one)

29b. Signature,

MARTINSON

31. Date filed (Month, Day, Year)

d title of certific

MAY 1 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARN.

M.D

32. Registrar's Signature

burial-transit and #A3agtz Hak たかいital Records, P.O. Box 68760, attending physician Physician/Medical the for use the detached has been signed by e 2 should be detact director, page 2 should Completed certificate Physician: Be မှ Division of After this funeral Certification: or Attending death. the Funeral Director; mpletely filled in by the

24 hours after

the Hospital

4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NI JOHNS BALTIMORE HO PKINS ŒN MED BAYVIEW 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 1 □ M 2 □ F Months Days Hours Min. 50 Yrs Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Dres 2 □ No Director Mary and 10e Street and Numb 10g. Citizen of What Country? 10f. Zip Code 2941 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 Yes 2 III If Yes, Give Year or Dates: 1 Never Married 2 Married 2 100 1 □Yes 2 No Specify: Blac Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Knivate Courselo, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ophelia Conway towell Edward ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, lity or Town, State, Zip Code) Carter-nother Ophelia Marylan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lion Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproxi ale Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Houk 5 disease or condition resulting in death) Due to (or as a consequence of): INTRA CEREBRAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEMORR CERTIFICATIO Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 🗀 No 2. 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**√1**No 1XYes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27, Manner of Death 1 ☑ Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

4940 EHSTERN AVENUE BALTIMORE MD 21224

Amend Items 1, per MD 18, 19a per Fh Film # 6968 10/21/2015 ds

or Amend Items 23a Pt1,25 per me 9837 oh 6 Health and Mental Hygiene
Certificate of Death

Reg. No. 2 For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Nunziata Nicolosi Di Cara Runci 2. Date of Death 3. Time of Death **Physician** Q:44 PM Kuncu April 30 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Yea NOV . 24 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Year) 1 🗆 M 2 🗙 F ´1931 Italy 77 214-44-2977 Director Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10b. County 28a-f show 1 ☐ Yes 2X No must be notified Director Maryland Harford Bel Air 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 23a or death with 104 Glenwood Road 21014 USA Funeral 14. Race - American Indian. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2∑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home the 18. Mother's Name (First, Middle, Maiden Surname) **Carmela** 17. Father's Name (First, Middle, Last) Be Filippo (nmn) Nicolosi <u>Giuseppa (nmn) Trimarchi</u> ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationshin *(Type. Print)* **Nunziata Kunci Brietich** Department of Health a Important: If item 27 is any injury or other trau once. Nancy Brletich / Daughter 2409 Edwards Manor Dr., Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 5-5-09 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Signature of Funeral Service Licensee Mcamas 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intraventricular Hemorrhage 24 houes **Physician** /Medical **Examiner** Probable Complications of Hypertension sequentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) AMINER N APPROVED BY MEDICAL EX that initiated events CERTIFICATI resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Yes 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ER/Outpatient 3 DOA nours after death.

neral Director; After this c Certification: To 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D66766 200 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 PUTTGEN H ADRIAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State back Registrar MAY 1 1 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 200°1 **Physician** 23140 M 0 0 FLORENCE E. RIVERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner AGNES BALTIMORE HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 M 2 X Director 215-28-1287 8-28-1931 PENNA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 10b. County 28a-f show event, the Medical Examiner must be notified at Director 1 Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 602 N. DUKELAND ST. Funeral 21216 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by Specify: BLACK 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4or 5+) **SEAMSTRESS** RETAIL 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ SUSIE TIGGLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERMAN PAYNE-EL(SON) 602 N. DUKELAND ST. BALTIMORE, MARYLAND 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important; If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL 5-18-2009 BALTIMORE, MARYLAND D. HIBN: R22. Name and Address of Facility PHILLIPS FUNERAL HOMS, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, str. x, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ia Cause (Final disease or condition resulting in death) **Physician** (don Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be execu Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) o 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed

FLORENC

page 2 should funeral director,

within 24 hours after deatl To the Funeral Director: filled in by

24a. Was an autopsy performed 1 □ Ýes 2 1No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Hnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature an title of certifier

Marod. M-D

D0067405

29d. Date signed (Month, Day, Year) 09

24b. Were autopsy findings available prior to completion of cause of death?

2 □ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON AUGNUE, BALTIMORE, HD 900 MASOOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical Certification: To



ORIGINAL

Division of Vital or Attending Physician:

Hospital

2/2

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2035 /Medical Charles Wesley Ruth May 11, 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Harford Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min. 1)ØM 2□ F Yrs Director 82 216-16-2195 06/16/1926 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 8 South Kelly Ave 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1942-1 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1942-1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Expediter Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Charles Wesley Ruth Alice Meadows 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 s' tment of Health ar tant: If item 27 Is Charles Wesley Ruth/Self 8 South Kelly Ave Bel Air, MD 21014 Important: If item 2 any injury or other once. 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 13 2009 Chesapeake Crematory Beltsville, Maryland WOLUGE 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEDE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Ye ar 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Xes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed?, yes 2) Hospital or Attending Physician: The Division of Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Xnpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00056607

State Registrar

HX

S.ATWOOD Ref.

602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#205

32. Registrar's Signature

ANGEZO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar 09 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yea **Physician** Amrendar 20:55 4 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore MD Travma 5. Social Security Number 480 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Year) Months Days Hours Director india Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show if of Health and Mental Hygiene.
If item 27 Is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Modical Examiner must be notified at Baltimore 1 ☐Yes 2 No Director MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ fes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ 3 Widowed 4 Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) echnician Bayview Medical Cent ayears 24-cors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be udolph J. ပ္ HMar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) jit. Baltimore. K. Berdes/Mother MD 21207 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. rowns ville VA Center 5-1-09 Crouns ville MD
22. Name and Address of Facility Voughn c. Greene funeral Sevs. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 8728 Liberty Rd Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhagic **Physician** how Shock /Medical Due to (or as a consequence of Examiner weeks 10H APPROVED BY MEDICAL EXAMINER ulopath 000 Sequentially list conditions, and a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-trans Sepsis Due to (or as a consequence of): P.Ó. Box 68760, Physician/Medical Multiple Injuries signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by After this certificate has been sign funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed (es 2) 1∐Yes or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of :11a 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospitar Committee within 24 hours after death.

To the Funeral Director: Afficulate of the funeral bit is the funeral of the funeral bit is the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part of the funeral part o 1 Natural Motor vehicle versus tree /11/09 0600 M 1 ☐ Yes 2 🗷 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1-695 @ Exit 27 (Dulaney Valley Road), Towson, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 1<1N6 0101236702 0 260 22 S. GEEEUR ST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Shawn BALTEMORE MD 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 132009 ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08 PM honie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNION MEMORIAL HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠** M 2□ F 43 Months Days Hours Min Director 01/01/1966 NC 246-19-5301 Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits show 10c. City. Town or Location Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3537 3RD STREET 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 ☐ Never Married 2 ☐ Married Yes 2 Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify: BLACK \$ 3 Widowed 4 Divorced Year or Dates: 1989 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAW ENFORCEMENT SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fil and Mental H is marked oth ပ ISAAC STOKES JO ANN MC NEILL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JO ANN MC CASKILL/MOTHER 3537 3RD ST. APT 1, BALTIMORE, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MC CLAIN FM. CEM. 05/16/2009 LITTLETON, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTIMORE, MD 21217 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Demo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has autopsy performed. Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending death. investigation nours after death neral Director; / filled in by the f 2 Accident 1 □Yes 2 □ No Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHARLES Month 3 00 A M COLTMAN Day Year SMITH, SR. 2009 5 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL Baltimore Center Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
WEST VIRGINIA 8. Date of Birth (Month, Day, 10-23-**Funeral** 1**X** M 2□ F Months Days 87 232-24-1400 Director Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Exar shart rust be notified at Director MD BALTIMORE ROSEDALE 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1506 SELING AVENUE 21237 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after Charle 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any Injury or other traumatic event, its item 20nce. Elementary/Secondary (0-12) College (1-4or 5+) **FOREMAN** 11 KOPPERS COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES SMITH LENORA ၉ (GRIFFITH) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY SMITH/WIFE 1506 SELING AVENUE ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HÉART OF MARY CEM. 5-15-2009 DUNDALK, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** maintrition Severe disease or condition resulting in death) MONTH /Medical Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be executed pleural effusion Due to (ords a consequence of) -tran and burialphysician s the burial Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) ned by the a P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 2 should 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) After 1 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MASIUADO, MAS 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 10 FRANKLIN SQUARE DR Baltimore DR minus vasiliades 9000 31. Date filed (Month, Day, Year) 32. Regis rar's Signature MAY 1 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2, 3perPHYS, G891, 5720/09, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** Annie Mae Simms 2009 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care-Roland Park Baltimore n/a 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Min. 1□M 2ĂF Months Days Hours 215-30-0805 89 1C-18-1919 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is fraction Expressed to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of 1) Yes 2 No Director MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4020 Hayward Avenue 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify. \$ Specify: African-American 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dietary Aide Baltimore CitySchools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thanes Downes Celeste Downes ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Simms/Son 4020 Hayward Avenue, Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-15-09 Louden Park Cemetery Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Whie Funeral home P.A. of Palto. Co. 9200 LibertyRoad, Randallstown, MD 21133 23a. Part / Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to lor as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2. No ed by the a detached f 9 Unknown 9 Unknown signed by the detach significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2√ No 24a. Was an 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the

After t

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

and

altimore, Maryland 21215-0036

28a-f show

State Registrar (Check or

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e of certific

29b. Signature

DHMH 17 Rev 1/2001

29gl. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Rea. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Runn Catherine Hwang Su 10 **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Season's Hospice Randallstown 9. Birthplace (State or Foreign Country) China 8. Date of Birth (Month, Day, Ye 2/2/1941 if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ 🏋 Min 68 462-51-5855 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Everning rough by notified at Baltimore 1 TXYes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or a may highry or other traumatic event, the Medical Eventual to use to the traumatic event, the Medical Eventual to use to one. USA 21201 8 Charles Plaza Apartment 2305 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍱 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Asian 1 □ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 4 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Li Chow Pin-Inn Hwang မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Charles Plaza, Apt. 2305, Baltimore, MD 21201 Bernard Su / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Crematory 20c. Location - City or Town, State Date 20a, Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 5/12/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services Moustoull PO Box 1413, Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Concer une **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🖼 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed3 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Applesan

29b. Signature and title of certifier



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death **Physician** Month /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, June 20, Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 192<u>2</u> 1 □ M 2 🗓 F Months Days Hours Min 143-18-2543 86 June Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Exacting inust be notified at Directo 1 ☐Yes 2 ☐ No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Obrecht Road 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No 2 Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. tem 27 Is marked other than other traumatic event, Inc. III 12 administrative assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Beckenstrater Mary Lillian Wheatley ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21610 Beallsville Road Barnesville, MD 20838 Marsha Vonduerchkheim/daughter item 2 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of IImportant: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4⊠ Donation 5☐Other ()Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street nn Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 1 ☐Yes 2 ☐No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**√**No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, or Attending Physician: s after death To the Hospital o within 24 hours aft To the Funeral DI completely filled in

death.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

or 28a-f show

items 23a

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"natural"

than

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Name and address of person

Year)

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 22:49 PM MAY MARY TERESA SHAW 2009 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. la N/A BALTIMURE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Days Hours Months 1 □ M 2 🖾 F 212-28-9691 78 6,1930 Pennsylvania Director Sept. Usual Residence of Decedent hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Evaminer must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1935 Robinwood Road 21222 Unites States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: ģ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Baltimore County I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 12 Years 6 Years Teacher is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental John Anthony Cortis Lucy Mary Ruggerio ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Yorkway Constance A. Notaro (Daughter) Dundalk, Maryland 21222 If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Cem. 5/14/2009 Elkridge, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Duda—Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardio pulmonery /Medical Due to (or as a consequence of): Examiner Small Cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an or Attending Physician: The law page 2 s autopsy performed2 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral f 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 10,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Justin Chronister, D.O. 4940 Eastern Avenue Baltimore, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 9:50 aM Billie Trent Sparks May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2503 Jerusalem Rd. Harford Joppa 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/17/1944 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Months Davs 215-40-9649 Tennessee 64 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Madical Experient must be notified at 1 ☐ Yes 2 ☐ No Director Md Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2503 Jerusalem Rd. 21085 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 🔀 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7; Ith and Mental Hygiene. 27 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Trent Ada unknown Dwight traumatic ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trau 2503 Jerusalem Rd. Joppa, Md. 21085 William Sparks, Jr. 1 and 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/09 Baltimore, Md. 4 Donation 5 Dother (Specify) 21. Signatur of Funeral 3 Schimunek Funeral Home, 1116. 9705 Belair Rd. Baltimore, Md. Name and Address of Facility
chimunek Funeral Home, Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery ctopic pregnancy Month Pregnant at time of death Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 1 ☐ Yes 2 🗷 Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **M**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direc 4 Homicide Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day Year) 29b. Signature and ti State Registrar

Evelyn Sadles May 6,2009 1303hng

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month РМ **Physician** 1:03 2009 May 6, Evelyn Sadler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore 1020 Valewood Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 27, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1 M 2000 1918 New Jersey 152-03-9349 90 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hygiens. Internation the state of the fire than a from and other than "ratural" or items 23a or 28a f show any Injury or other traumatic event, Its. Internation to other traumatic event, Its. Internation 28a-f shov 1 ☐ Yes 2 Total Director Towson Md. **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 1020 Valewood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: Specify ò 3 ₩idowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ం Cook Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Towson, Maryland 21204 Joan Magnani/Neighbor 1021 Valewood Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/09 <u>Jarrettsville, Md.</u> 4 Donation 5 Other (Specify) Jarrettsville Cem. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funoral Service Licensee Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. andiavas culor Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □ Yes 2 ■ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number pleted cause of death (Item 23a) (Type Print) 6 Trim ble Hill CT. Luthonville, Md 21093 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary 446 / Department or Aeafin End Mental Hyglene, WS 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 11, 2009 SACHS **Physician** BERNARD Μ. 12:45P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A Baltimore MILFORD MANOR If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, JUNE 30 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1925 MARYLAND 1 X M 2 □ F 213-20-4073 83 Director Usual Residence of Decedent 10b. County Baltimore 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it will be any in a count by multiple and once. BALTIMORE Glyndon 1 ☐ Yes 21 No MD Director 10f. Zip Code 21071 10g. Citizen of What Country? 10e. Street and Number 3675 BUTLER ROAD USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERMARKET MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **MEYERS** BESSIE SACHS HARRY ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3675 BUTLER ROAD GLYNDON, MARYLAND 21071 19a. Informant's Name/Relationship (Type. Print) FLORENCE SACHS/WIFE 20c. Location - City or Town, State Date 20a. Method of Disposition 20h Floge of Disposition (Hame of Ece) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/2009 BALTIMORE, MD WOODMOOR HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) allewoon **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions ontribating to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? rune 24a. Was an has autopsy perform certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☑ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours af Funeral D etely filled in 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ans cause of death (Item 23a) (Type, Print) 838 e State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan		artmen <i>rtificat</i>			and M	lental Hy	gien Reg. N	200	9	154	64
			Decedent's Name (First, Middle, La	st)							2. Date of D	eath			3. Time of D	eath
	Physici /Medi		Emily T.	Szr	om						May	9,	200 ⁹	ar	7:40	ΝΑС
	Examir		4a. Facility Name (If not institution, giv	e street and numb	er)		4b. City,	Town, or	Location o	of Death			c. County of I			
			Franklin Woods	Nursi	ng Ho	me	Ro	seda	ale			E	Baltim	ore	≘	
	Funeral Director		5. Social Security Number 6. S 203-20-3902	ex 7. □ M 2□ X F	Age (In yrs. 81	last birthday) Yrs.	If Under Months	1 Year_ Days	If Under : Hours	24 Hrs. Min.	8. Date of Bi (Month, D Mar 2	rth av Yea	¹⁾ 928P∈	Birthpl Count	ace (State or . ry) Sylvar	Foreign nia
	pu 🛦		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ontion							1/	ld Innida Cib.	Limite
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	ms 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13.	Was Deced	dent of Hi	spanic Orio	gin? (Spe	cify Yes or N	0-	14. Race - /		an Indian,	
36	swithin 72 hours after death with the Maryland siene. I than "natural", or Items 23e or 28e-f ehow the Madicul Examiner must be notified at the Madicul Examiner.	by Fur	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2: If Yes, Give Year or Date	₽ No		lfYes,speo 1 □ Yes	cify Cuba	n, Mexican Specify:	, Puerto	Rican, etc.)		Black, V	Vhite, e Jhi		
Š	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ition			16b.	Kind of Busin			
215	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4	or 5+)	(Give	kind of wor DO NOT us	rk done d	urina most	of worki	ng				,	
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p	be filed that Hygie of other is	Be (17. Father's Name (First, Middle, Last,								(First, Middle					
Maryland 21215-0036	should be nd Mental marked o	2	John Szrom						Vic	tori	la Kar	pir	nska			
Jar	01 00 00 00		19a. Informant's Name/Relationship (or Town, Sta			1224
	s 1 and 2 of Health item 27 I		Sigismund J.	SZrom/b		_			Avei		40000					
Baltimore,	Pages nent of h ant: If ite ury or of		20a. Method of Disposition 1 Burial 2 Cremation 3		ite C	Place of Dispo cemetery, crea	natory or o	ther place			ate		Location - City			1
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Ba	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licer	398									imore			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau one cause on eac	sed the deat n line.	h. Do not ent	er the mod	e of dying	, such as	cardiac c	r respiratory a	ırrest,			Approximate Interval Betwe	aen
	Pnysician	i II	Immediate Cause (Final disease or condition	a	MET	A.ST	ATI	C	END	OF	ETRI	42	CAN	CE	Onset and De	ath
	/Medical Examiner		resulting in death)	Due to (or	as a conseq											
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$\overline{}$	ted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence or):										
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8760,	cate be executed physician and the burial-transit	dicai E	(d												
89		0		0.												
Вох	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of	deliver	у	
œ.	that the death ed by the atte detached for	icia	in the past 12 months? 1 \(\sum \text{Yes} 2 \(\overline{\text{Vo}}\)	1☐Live birth	at time of di		Ectopic pro Other (sp						Month	1	Day Ye	ar
P.O.	at the by th	hys	9 Unknown	9□ Unknowr												
	res tha igned be del	þ	Part II. Other significant conditions of				nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contribut	e to the	e cause of dea	ath?
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Vital Records,	has bo	Completed	ATRIAL	FIBR	ILLA	NON					24a. Was		24b. Were	autop	sy findings av	ailable
<u> </u>		Con									perfo 1 ☐ Yes	ormed? 2001	deat	h?	2 CHO	
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Lli						of Death	(Check only	one)				
of	Phys this al dir	٦.	1 Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatien			4 CLANGE				6 ☐Other (5	Specify		
L C	ding Ph h. After th funeral	io	1 Natural 5 Pending		Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe	how inji	ury occurred			
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D.	rs after al Dira	Certification;	4 Homicide determined	building,	etc. (Specify	y)	set, ractory	, onice			City or To	wn, Sta	te)	riura	TIOUIS PAULIDE	и,
0	To the Hospitel or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	Medical	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be liner: On the basis and manner	of examinal	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	l place, a	and due to the ad at the time,	cause(: date ar	s) and manne nd place, and	r as sta due to	ited. the cause(s)	
	Withir To th comp	Me	29b. Signature and title of certifier				29c.	. License	number			29d. D	ate signed (M	onth, E	lay, Year)	
			Vin Paral	all 1.	10		7)4	000	8		<	-/11/0	9		
		1	30. Nume and address of person who				Print)		_					-		
_			JIM PAFSHALL	9105	FRA	NYLIN	1 54	EUAJ	RE D	R.	BALT	MO	PE IN	10		
	Sta		31. Date filed (Month, Day, Year) MAV 1 3 2009	2. Regi	strar's Signa	ture far	w									
	Registra	al l	M V A B B ANDS	1 Boll for	W Fig.	14 680										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland 50 Penartment of Health and Mental Hygiene 1 - For A Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2:303M Lula DeVon Toney May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Janua 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Carolina Months Days Hours 1 ☐ M 2 🖵 F 219-26-8679 72 1936N. Ďirector 18, May Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Baltimore **X**□Yes 2□No Director N/AMaryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 4317 Park Heights Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Ś 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatin exceed. 12th grade College (1-4or 5+) Hecht Co. Sales Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Mae Eaton Williams ౖ 19a. Informant's Name/Relationship (Type. Print)
Joyce Williams/ daughter 43 Mailing Address (Street and Number of Rural Route Number Bay L'Tryon State Zip Ma) 21215 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 5/7/09 Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Juneral Service Licens 5240 Reisterstown Road Baltimore, Md21214 22. Par . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause Final disease or condit in resulting in death) **Physician** amorchas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for selectionesquenes Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): com attending physician and for use as the burial-trar Physician/Medical CERTIFICATIO 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the detached 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an has page 2 autopsy certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 1 1 2009

30. Name and address of pereon who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Agnatu

P.O. Box 68760

Division of Vital Records,"

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lorraine C. Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Arunde1 Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 1 ☐ M 2 👿 F Months Days Hours Min. Dec 9, 71 Director 1937 Maryland 216-34-2334 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show 1 ☐ Yes 2√ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Stiemly Avenue 21060 USA "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married þ 1 ☐ Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) College (1-4or 5+) Elementary/Secondary (0-12) claims processor healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward James Byczynski Ida Alekzalza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Thompson/spouse 201 Stiemly Avenue Glen Burnie, MD Department of Health Important: If Item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROPALA S. Wards State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. P tt1. Enter the disea e, r complications that caused the shock, or heart failure. List only one cause on each line r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a lonse uence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Cher (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760 signed by the a d be detached for After this certificate has funeral director, page 2 ours after death.

neral Director; After this

y filled in by the funeral di within 24 hours a

To the Funeral L соmpletely

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

2

State Registrar

Medical

29a. Certifier

30. Name and address of

maken 31. Date filed (Month, Day and manner stated.

completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Glen Burne.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year O 200 AM Dorothy C. Toler 200 4a_Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltmore aint lignes Hospita If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 😾 F 86 Apr 24, 1923 240-26-5802 North Carolina Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits Baltimore 1 ☐ Yes 2√ No CAtonsville 10e. Street and Number 719 Maiden Choice Lane #HR 421 10f. Zip Code 10g. Citizen of What Country? 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) 12 College (1-4or 5+) bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Alexander Cratch Sallie Lamm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cynthia Nelson/daughter 8846 Willliams Mill Pond Road Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21, Signature of Euneral Service Ronal C 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street iceLicensee S. Wade Baltimore, MD 21201 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or condition resulting in death) ac 0001CI Due to (or at a consequence of): oronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the nast 12 mont

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

MD

Director

Funeral

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event, the Wedical Evantersones.

Baltimore, Maryland 21215-0036

death with the Maryland

and burial-trar attending physician as for use the page 2 should

an/Medical

executed law requires that the death certificate be Hospital or Attending Physician: The 24 hours after death Property Process completely filled in by the

Division of Vital Records, P.O. Box 68760,

Physici	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Oth 9 ☐ Unknown	ner (specify)								
by	Part II. Other significant conditions	contributing to death but not resulting in the underl	ying cause given in Part I.		use contribute to the cause of death?						
Completed				24a. Was an autopsy performed? 1 ∐Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
e	25. Was case referred to medical		26. Place of Death (Check only one)								
70 B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 TER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
rtification: 7	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28d. Describe how injur	ry occurred							
a)	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
dical C			s) and manner as stated. d place, and due to the cause(s)								
Me	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)						

State Registrar

within 2 To the I

ame and address of person who completed cause of death (Item 23a) (Type, Print)

anni

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** MAYDay B. X991719 5:43 FM /Medical William Frank Thompson Sr 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Ealtimore **Examiner** Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 3 M 2 □ F Months | Days Hours Min. Director 72 213-34-0071 11/29/1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It a Martical Evenants. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 300

12. Was Decedent Ever in U.S. Armed Forces?

1 Myes 2 No If Yes, Give Funeral 1000 E. Joppa Rd. 21286 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: No Yeu Specify: 夕 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Refridgerator & A/C Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၀ John Thompson Luella Wertman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Thompson/Wife 1000 E. Joppa Rd. Apt. 300 Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 1 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2009

22. Name and Address of Facility Beltsville, Maryland 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 23a. Part1. Filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21286 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE ON CHRONIC RESPIRATORY FAILURE Physician /Medical Due to (or as a consequence of):
CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed NONISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has be page 2 s AORTIC STENOSIS autopsy performed? Yes 2 2 No certificate 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Nnpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural ie Funeral Director: A Funeral Director: A pletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3Ø263 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS 7601 OSLER DRIVE TOWSON, MARYLAND 21204 KHOO D 32. Registrar's Signatur 31. Date filed State

DHMH 17 Rev 1/2001

Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

_	Registrar	Certi	ficate of Death	Reg. f	No.						
n	1. Decedent's Name (First, Middle, Last)				Day Year	3. Time of Death					
ai	DeHaven Samuel Charles 4a. Facility Name (If not institution, give street and number		b. City, Town, or Location of Death		2009 4c. County of Deat	<u>, , , , , , , , , , , , , , , , , , , </u>					
r	Sinai Hospital of	Baltimore	Baltimore (1	'tv	/ N/A						
-	5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday)	f Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Fore					
	216-42-7704 1XM 2□F	64 Yrs.	Days Hours Will.	5-23-194		RYLAND					
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	ion			10d. Inside City Lim					
5	MD. N/A	BALTIMORE				1 X Yes 2 □ 1					
Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?					
	3600 MARMON AVE.		21207		USA						
runeral	11. Marital Status 12. Was Deceder Armed Forces	6? If Ye	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White						
Š	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates		lYes 2 No Specify:		Specify: BLA	pecify: BLACK					
	15. Decedent's Education	16a. Deceden	t's Usual Occupation		Kind of Business/	Industry					
1	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	(5+) life. DO	d of work done during most of work NOT use retired)	ing		_					
completed		CLER		CHURCH me (First, Middle, Maiden Surname)							
מ	17. Father's Name (First, Middle, Last)			MOTT DRED CONLIAN							
2	ROBERT A. VAUGHN 19a. Informant's Name/Relationship (Type. Print)	10h Mailing /	MILDRED CONWAY								
	EMMA VAUGHN (WIFE)		illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OO MARMON AVE. BALTIMORE, MARYLAND 21207								
- 1	20a. Method of Disposition	20b. Place of Disposition	on (Name of		Location - City or						
	1 Burial 2 □ Cemation 3 □ Removal from Stat	e ARBUTUS ME	EMORIAL PARK 5-14	4-2009 BAL	TIMORE, 1	MARYLAND					
	21. Signature of Fulleral Service Licensee IONATHA	N. P. HIBNER N. N.	lame and Address of Facility RE								
23a. Part1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
	shock, repeart failure. List only one cause on each	line.				Approximate Interval Between Onset and Death					
	Immediate Cause (Final disease or Condition resulting in death)	ute Myora	ardial Infar	ction							
	Due to (or a		eart failure								
0	if any, leading to immediate Due to (or a	is a consequence of):	cuil failuic	•	+						
LAGIIIII	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
	resulting in death) Last Due to (or a	s a consequence of):									
I Ca	d										
ME	IF FEMALE: 23c. If yes, outcom	ne of pregnancy									
Priysician/Medical	in the past 12 months?	2 ☐ Fetal death 3 ☐ E	ctopic pregnancy ther <i>(specify)</i>		23d. Date of del Month	Day Year					
133	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		mor (opcony)								
y V	Part II. Other significant conditions contributing to death	but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death					
				1 ☐ Yes	2 □ No 3 □ Pr	robably 4 12 Unknown					
				24a. Was an autopsy	24b. Were au	topsy findings availa					
Completed				performed	? death?	2 No					
3	25. Was case referred to medical examiner?			h (Check only one)							
2	1 ☐ Yes 2 ☐ Yoo Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of Ir			ome 5 Residence		cify)					
	1 Natural 5 Pending (Month, E	njury 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred						
oci micanon:	3 Suicide 6 Could not be 28e. Place of I	njury - At home, farm, street,		28f. Location (Street	and Number or Ru	ural Route Number,					
3	4 ☐ Homicide determined building,	etc. (Specify)		City or Town, St.		,					
ųΙ	00-0-00-00-00-00-00-00-00-00-00-00-00-0	at of my knowledge, death or	death occurred at the time, date and place, and due to the cause(s for investigation, in my opinion, death occurred at the time, date and			s stated.					
	29a. Certifier 1 Certifying Physician: To the bes	of examination and/or invoc	tigation in my opinion death com-	red at the time date :	date and place, and due to the cause(s)						
	(Check only 2 Medical Examiner: On the basis and manner:	of examination and/or inves	tigation, in my opinion, death occur	red at the time, date a	and place, and due	to the cause(s)					
Medical Ce	(Check only 2 Medical Examiner: On the basis	of examination and/or inves	29c. License number H 6 8 2 1 4	red at the time, date a	and place, and due Date signed (Monti	e to the cause(s)					

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yaniv Berger, DO Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AV 1 3 2009

		1 - State Amend Items Registrar		,25,27	nd / Depa •28a-f Cer	artment tricate	of H	ealth a 8 91, 0 9 eath				09	1547
Physici		1. Decedent's Name (First, Middle, La:	st)		W	h.t Ac	11			Date of Dear Sonth Lock	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, giv	e street and numb	per) ·			_	Location of			4c. County		
		The Johns Hopkins H				Baltim				48:4		0.5:	
Funeral Director		210-28-0307	Man 2 □ F	7. Age (In yrs.	/ast birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	Date of Birth Month, Day, t. 13	Year) , 1931	Coun	place (State or Foreign try) yland
land low t		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limit
Mary la-f sh fied a	ctor	Maryland		Ва	ltimore	9							1 🔀 Yes 2 🗌 No
/ith the	Director	10e. Street and Number			_	10f. Zip-C	ode			1	0g. Citizen of V	Vhat Cour	atry?
eath v	Funeral	4008 N. Rogers Av	renue 12. Was Deced	lent Ever in II	S 13	Was Decede		L207	in? (Specify	Yes or No.	USA 14 Rac	e - Americ	an Indian,
be filed within 72 hours after death with the Maryland Hydjene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	Marital Status Never Married 2 ☐ Married Widowed 4 ☒ Divorced	Armed Ford 1 Yes If Yes, Give Year or Date	ces? 2 🔀 No		f Yes, specify		Specify:	in? (Specify Puerto Ricar	n, etc.)	Blac	ck, White,	etc. hite
2 hour atural	ted t	15. Decedent's E	ducation			dent's Usual			a f a string		16b. Kind of B	usiness/Ir	dustry
thin 73 e. an "na Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work DO NOT use	retired)	J	or working				
filed within Hygiene. other than " ent, the Mec		12 17. Father's Name (First, Middle, Last)			S	llvers	mith		r's Name (Fir	st Middle	Silve Maiden Surnar		
d be fi	To Be	Charles Exum Whi							lle T.			,	
s 1 and 2 should be fi f Health and Mental H item 27 is marked otl other traumatic even	1	19a. Informant's Name/Relationship (Lisa Stalnaker		ughter				and Numbe	r or Rural Ro	ute Numbe	or, Cify or Town,		
is 1 and of Healt item 2 other		20a. Method of Disposition 1 Burial 2 Cremation 3 □		20b.	Place of Dispo	sition (Name	e of		Date	., 2	20c. Location		
trant: If ite		4 Donation 5 Other (Special	y)	Me	adowri	lge Me	m	Park :	3/6/20	09	Elkridg	ge, M	aryland
permit. Page Department of Important: If any Injury or once.		21. Signature of Juneral Service Liver									e, Înc. onsvill		ab Witzke D 21228
Physician		23a. Part 1. Enter the dise or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	used the deal ch line. b dura	th. Do not ent	er the mode	of dyin	g, such as	cardiac or re	spiratory ar	rest,		Approximate Interval Between Onset and Death
/Medical Examiner	L	resulting in death) Sequentially list conditions.	Due to (d	r as a consec	quence of): Lecal)		•	1.	11		7 days
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dae to (c	में के व दिलाइटर	duence oi):		(~ 1 A.	TO CHE	AMINER		
death certificate be executed e attending physician and ed for use as the bunal-transit	dical Exa	that initiated events resulting in death) Last	C. Due to (c	or as a consec	quence of):		CERT	FICATION AS	PROVESTRY	Мен			
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ne death certifi the attending ched for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		rth 2 🗌 Fet ant at time of o	al death 3	Ctopic pre						ite of deliventh	ery Day Year
The law requires that the der te has been signed by the ar page 2 should be detached i	by	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the	underlying ca	ause giv	ren in Part I	l	23e. Did to			the cause of death? bably 4 Unknov
The law requate has been page 2 shoul	Completed				•					24a. Was a autops perfor 1 Yes	sy 🖊	prior to co death?	opsy findings availab ompletion of cause of 2 No
	Be (25. Was case referred to medical examiner?	Hospital:			,	LOtho		of Death (Ch				
hys ald	2	1 X Yes 2 No	28a. Date of		ER/Outpatier 28b. Time o		C. Injury	4 🗆 Mui			ence 6 - Oth		ý)
tending F death. tor: After t	tion	atural 5 Pending 2 X Accident investigatio	n 02/22	/2009	Unknov		Work	? ′es 2 X N			t fell.		
7 0 5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of buildin	of injury - At h g, etc. <i>(Speci</i> 1 1 tat	ome, farm, str	eet, factory, o	office			Cify or Town	Street and Num. n, State) 540 Stown, M	1 01	al Route Number, d Court Ro
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		30. Name and address of person who		e of death (Ite	em 23a) (Type,	Print)			600 No	rth Wo	lfe St, Ba	ltimo	re, MD, 212
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			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			giene	11119	15471
	Physic	an	1. Decedent's Name (First, Middle, Last,	John	Wat			2. Date of De Month	ath Day	y Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give				r Location of Death	MAY		County of Deal	11:45p M
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	Funeral Director		242-42-4199	7. Ag M 2□F	e (In yrs. last birthday, 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 6-8-19	th ly, Year) 130	9. Birt Co NOR	hplace (State or Foreign untry) TH CAROLINA
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	e-fsh	ctor	MD. N/A		BALTIMO	ORE					1X Yes 2 □ No
	with th	Director	10e. Street and Number	11D		10f. Zip Code	6			zen of What Co	ountry?
	ns 23	Funeral	2305 GARRISON BI	12. Was Decedent	Ever in U.S. 13.	2121 Was Decedent of H If Yes, specify Cuba		pecify Yes or No		ISA 14. Race - Ame	
21215-0036	within 72 hours after death with the Maryland one. than "netural", or Itams 23e or 28e-1 show the Madical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	NO I	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerti	o Rican, etc.)	i	Black, White Specify: BI	
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Baltimore,	permit. Page Department Importent: If any injury o		21. Signature of Fune Service Licens	JONATH			•				LAND 21217
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	/Medical Examiner		diseas of condition resulting in death)	Due to (or as	a consequence of):	is regione					1
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۵.	de de		Part II. Other significant conditions cor	ntributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?
rds	quires an sign uld be	ed by				_		1 🗆 1	Yes 2	Mo 3□Pr	obably 4 Unknown
Vital Records,	e law has b	ompleted						24a. Was autor perfo		prior to a	itopsy findings available completion of cause of
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Division	al or Attandii safter death. I Diractor: A d in by the fu	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (City or To			ural Route Number,
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7 1	1		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,	Print)	Reister	itan	MO	2113	34
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Kimberl 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOY E If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1□ M 3√7F Months Hours Min. **Director** 214-02-0837 41 1967 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2√∑ No Maryland Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral Guadelupe Drive 21157 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 2 3 ☐ Widowed 4 ☑ Divorced Black 5 4 1 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Assistant</u> Food Distributor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any linjury or other traumatic evance. ပ G. Edward Dunlap, Sr. Barbara Chappell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, Maryland 21157 Edward G. Dunlap, Sr. Father <u>1304 Guadelupe Drive</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Druid Ridge Cemetery 5-14-2008 PIkesville Maryland 21 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner ORONALY YISTEL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran LDIABETE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Pregnant at time of death 5 Other (specify) ed by the 9 I linknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an s certificate has t irector, page 2 s autopsy performed? 1 Yes 2 No 2 No ours after death. neral Director: After this certificat v filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number WPI 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ဂ္ဂ

State Registrar

31. Date filed (Month, Day, Year)

MAY 1 3 2009

J-SUBER

32. Registrar's Signature

30. Name and addr 49s of person who completed cause of death (Item 23a) (Type, Print)

1437130184

Green St Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month MAYDay3 20019 4:12 Frances Olivia Akeo /Medical 4a. Facility Name (If not institution, give street and number) Center 4b. City, Town, or Location of Death 4c. County of Death in one Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 19, 1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Maryland 219-44-7079 63 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner met be notified at Director PA York 1 ☐ Yes 2X No Stewartstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or items and injury or other traumatic event, the Medical Exanting instituen once. 120 Gateshead Drive 17363 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Y} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White þ 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Assisted Living Elementary/Secondary (0-12) 12 College (1-4or 5+) Housekeeper Facility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Austin Myers Susanna Sheeler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas G. Myers, Brother 14308 W. Phoenix Ave., Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation
Direct Service 20a. Method of Disposition May 6, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State York, PA 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.J. Hartenstein Mortuary, Inc. 10/1 24 Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death A therosclantic Immediate Cause (Final Physician Cardio vas unlas disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner consequence of): pertision Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 24a. Was an autopsy performed: 1 ☐Yes 2 ☐No 1 □Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kioun non-Dow

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State Registrar 31. Date filed (Month, Day, Year)

Contan 5 t

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27 2009 Year РМ April 7:30 William Sherman Burdette, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charles Indian Head 3450 Laurel Drive 8. Date of Birth (Month, Day, Yea April 18, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1950 Washington D.C 5. Social Security Number 7. Age (In yrs. last birthday) Year) Days 1 ★M 2 □ F Months Hours 59 215-56-9896 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 → No Indian Head Charles Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20640 United States 3450 Laurel Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Firefighter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Yanofsky William Sherman Burdette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3450 Laurel Drive Indian Head, Maryland 20640 Mary Carney/Sister 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 28,2009 Charlotte Hall, MD Brinsfield-Echols 21. Signature of Paneral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. 211 St. Mary's Ave. La Plata, MD 20646 M01458 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NO 10disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? known 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ Mo 26. Place of Death (Check only one

Physician /Medical Examiner

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Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

If Hygiene.

permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trau

marked other alth and Mental Hv.

Maryland 21215-0036

Baltimore,

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g physician and as the burial-transit attending p for use as t signed by t I be detach peen cate has page 2 s certificate director After the

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

the Hospital or Attending Physician:

death.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

23b. Was decedent pregnant

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certified

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

31. Date filed (Month, Day, Ye 29 2009

32. Registrar's Signature

State

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month William Buckingham 2009 12:00 p M April 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Augsburg Lutheran Home Lochearn If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number **Funeral** Days 1**X** M 2□ F 29 215-12-2781 89 MD Director Mar Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Lochearn Baltimore 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA 6811 Campfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □**X**es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married WII 1 ☐ Yes 2 ☐ No Specify: Completed by White 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Greenspring Dairy Milkman 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Caron Peirce Buckingham ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Kopeikin/daughter Baltimore, MD 5210 St. Albans Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/28/2009 Pleasant Grove Cem Boring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Printed Printerfadily Home and Chapel, P.A. M 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death THEROSCHEROTIC CEREBROVASCULAR Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequênce of) Examiner n any, leading to minediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month for in the past 12 months? Day 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part NOther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by NEUMONIA 1 □ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 1 ☐ Yes after death.

Director: After this certificate | 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 2∏.**K**0 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide n 24 hours af Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 7 JL State

the

Registrar

29b. Signature/and title of certifier

sheen

APR 2

2835 Smith AVE SUITE 203, BALTO MD HOOT LAKHAMI, MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature

8

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Depa	rtment of Health ar	nd Mental Hyg	jien e () ()

		1 - For State Registrar	State of Maryla		artment of F		Reg		154/6
Physici /Medic	cal	Decedent's Name (First, Middle, Last Nancy Bell Bart As Facility Name (If not institution, give	on		Ab City Town	or Location of Deat		Day Year 29 2009 4c. County of Deat	3. Time of Death
Examin Funeral Director	ier	4 Inverness Drive 5. Social Security Number 6. Security 10 10 10 10 10 10 10 10 10 10 10 10 10		rs. last birthday) Yrs.	North If Under 1 Year Months Days	East	8. Date of Birth	Cecil 9. Birti	hplace (State or Fore untry) inia
8a-f ehow otified at	Director	Usual Residence of Decedent	10c. (City, Town or Lo	East				10d. Inside City Lim 1 ☐ Yes ※
a or 2 Lben		10e. Street and Number			10f. Zip Code	1		. Citizen of What Co	
ei', or items 23a or 28a-f show Examiner a ust be notified at	by Funeral	4 Inverness Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1		2190 Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	ncan Indian,
iene. r then "naturel", c the Medical Exa	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking 16	b. Kind of Business/	Industry
al Hyg	Be	12 17. Father's Name (First, Middle, Last) David E. Poe			Homemake	18. Mother's Na	me (First, Middle, Ma.) E. Arnold	Own Home iden Sumame)	2
nd Mental marked o	P	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street		ural Route Number, C	city or Town, State, 2	Zip Code)
Deparment of Health and Mentifunductions: If Item 27 is marked any Injury or other traumatic educe.		Hazel Eastridge / 20a. Method of Disposition **Experimental 2 Cremation 3 F **A Donation 5 Other (Specify) 21. Signature of Fig. 21 service Lice.	20b	Place of Dispo cemetery, crei orth Eas Cemete	esition (Name of matory or other pla st Method ry 2. Name and Addre	ist May	North Eas Date 20 2,2009 No rouch Fune eet, North	orth East, eral Home	Town, State Maryland
Medical and prize transit transit transit	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	-	еди <i>эпсэ о</i> ђ.	CARD Cosular	Accid	1THY		Chset and Deat
by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
signed d be de	b	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause gn	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death
cate has	Completed						24a. Was an autopsy performe 1 Yes 2	prior to	topsy findings avail completion of cause 2 No
n. After this funeral di	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spe	28b. Time o Injury	f 28c. Inju. Wo	ner: 4□ Nursing H	ath (Check only one) Home 5 Residence 28d. Describe how 28f. Location (Stree City or Town, 5	injury occurred	
within 24 nours after deals To the Funerel Director: completely filled in by the	edical Cer	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat	h occurred at the tr vestigation, in my o	me, date and place	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the comple	Med	29b. Signature and title of certifier			29c. Licens	se number 3 0 6 5 7 3 3		. Date signed (Monti	-
2		30. Name and address of person who co				IGH STA	REET E	LKPN, H	15 21921

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03616 State of Maryland / Department of Health and Mental Hygiene Rondie Wayne Baldwin 15477 2009 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 5, 2009 1430 hrs Medical Examiner Rondie Wayne Baldwin 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Cecil North East River at 60 Sandy Cove Road North East If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country)Maryland Director August 29, 1957 1 X M 2 F 212-70-2417 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No 23a or 28a-f show notified at once. Rising Sun Maryland Cecil death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 21911 United States 281 Lombard Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' 2 X Married 1 Never Married 2 X No Yes Specify: White Yes 2 X No specify: I and 2 should be filed within 72 hours after Health and Mental Hygiene. If Yes, Give Year 3 Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " 5-0036 Self-employed Carpenter Carpentry 11 Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary M. Brock Be Rondie M. Baldwin imatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ို MD other traumat 281 Lombard Road, Rising Sun, MD Jennifer Baldwin/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, May 8, Cherry Hill 1 X Burial 2 Cremation 3 Removal from State Pages 1 of I rtant: P 2009 Cherry Hill, MD Donation 5 Other Specify Methodist Cemetery 22. Name and Address of Facility
Hicks Home for Funerals, P.A.

100 T. Stockton Street. Elkton 21. Signature of Funeral Service Licenses 21921 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Drowning Medical Death Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and hysician/Medical 23a,27,perME, g891 8/13/09 TT &28a-f X UNPENDED ending physician use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box requires that the death 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö s been signed by should be detach Yes 2 ✔ No 3 ò Probably 4 Unknown σ, Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy The law certificate has performed? death? 2 No 1 🗸 Yes ✓ Yes 2 e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi 26 Place of Death (Check only one) 25. Was case referred to medical Be Division of Vital examiner? Other₄ Hospital: 1 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 Inpatient 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural Yes 2 X No Pending Director: 4/30/09 7:30 pm 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) North East River filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide water Sandy Cove Rd. North East, MD determined Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State 31. Date filed (Month, Day, Year)
Registrar

29b.

Signalure and title of certifie

Laron Locke MD.

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29c, License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 6, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25 tote, 26 Maryland/ Department of Headthung Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:25 a M Veeraiah B. Chedalavada (aka - William B. Chedalavada) March 29 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F Director January 13, 1910 India 219-88-9391 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show the Medical Examinent nest be notified at 1 X Yes 2 □ No Director Silver Spring Maryland Montgomery 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 23a 804 University Blvd. East, Apt. #1 20903 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 ò If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify. þ Specify 3 ₩ Widowed 4 Divorced "natural", Asian Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 than Elementary/Secondary (0-12) College (1-4or 5+) Marga Darshi Health Magazine Editor marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Bulliah Chedalavada Bulli Venkamma ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Enoch W. Chedalavada - Son 4511 Naples Avenue, Beltsville, Maryland 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery: 04/03/2009 Adelphi, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Na 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or ondition resulting in death) Physician Fungemia /Medical Due to (or as a consequence of): Examiner Pneumonia APPROVED BY MEDICAL ENAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Vertebral Fracture that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 38 attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnance ò Month Day Year 5 Other (specify) Ö ☐Yes 2☐No the 9 Unknown 9 Unknown ed by the σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🕱 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 No Certification: To 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending Subject pedestrian struck by after death. investigation 12/11/2008 1 ☐ Yes 2 X No |4:15 p. ^M 2 X Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Flural Route Number, City or Town, State) New Hampshire Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Roadway at Merrimac Drive, Hyattsville Hospital 24 hours a 29a Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 2005 6063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanwaljit Kaur Nagi, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY 6,2009 Year NAOMI CATHERINE CARBONE 6:05P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES CO.NUR.& REHAB.CENTER LA PLATA CHARLES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign W • VA) 8. Date of Birth **Funeral** Min 10-16-1921 1 □ M 2√2 F Days 235-26-1061 87 Yrs Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examinar must be notified at Director MD. CHARLES LA PLATA 1X Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 10200 LA PLATA ROAD 20646 U.S.A. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2√2 No Specify ģ 3 ₩idowed 4 Divorced Specify: WHITE "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) CASHIER AMERICAN AIRLINES 12th permit Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked any injury or other to one. marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KEN OSBORNE ZETTIE ESTEP ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY CARBONE-SON 5202 FLOUNDER CT. WEST WALDORF, MD. 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FOREST LAWN MEM.GARDEN 5-11-09 FT.LAUDERDALE, FL 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LAPLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ermina disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy ģ Month Day Year 5 ☐ Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Physician: The 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No after death Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5635 gistrar's Signature

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	State of Maryland	/ Department	of He	ealth and	Menta	al Hygiene

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Aloysuis Edward Er	1- For State Certificate of Death Reg. No.								09 154	8					
Physician/ Medical Examiner	1.	Decedent's Name (First, Mid Aloysius E. En								2	Date of Deat Month April 27, 2	h Day 00 9	Year	3. Time of Death 1745 hrs	
*	48	a. Facility Name (if not institu 50 Williams Road	tion, give stre				b. City, To Elkton	wn, or Lo		Death		4c.	County of Death		
Funeral Director	5.	Social Security Number 218-18-3257	6. Sex		e (In yrs. la 86	ast birthday) Yrs	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of Bir Ma	th(MM/I y 29, 1	Forei	thplace (State or gn puntry) NJ	
and show any nce. Or	11	sual Residence of Decedent Oa. State 10b. Coun MD C	ecil			Town or Locati Elkton								10d. Inside City Limits 1 Yes 2 No	
the Maryland is or 28a-f sh utified at one Director	1	0e. Street and Number 50 Williams Ro	i.					1921					zen of What Cou USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other tran "natural", or items 23a or 28a-f show any injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director			Married 1	s, Give Year	No.	1	es, specify Yes 2	Cuban, No	Mexican, l	Puerto F			14. Race - Ame White, etc. Specify: Kind of Business	White	
5-0036 ed within 72 hours tygiene. the Medical Exam Completed	- Paradi	15. Decedent's Education (S Elementary/Secondary (0-1 2		ghest grade col College (1-4 or		16a. Deceden during m	ost of work	ing life. I	DO NOT u	ise retire	ed)		Agricult		
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Balti permit. Departu Importi injury o		4 Donation 5 Other Specify: 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, M 23a. Part INEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Retyrence													_
Physician / Medical caminer	1 0	Ba. Part Ixenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hypertensive Atherosclerotic Cardiovascular Disease r condition resulting in death) b. Due to (or as a consequence of): b. Due to or as a consequence of): ause. Enter Underlying Cause c											Between Onset an Death	t	
(0), te be executed ysician and burial - transit		events resulting in death) La	st Due	to (or as a con	sequence (of):									-
, P.O. Box 68760, res that the death certificate be ex signed by the attending physician be detached for use as the burial of the physician Medician SICIATIVIN	UNPENDED F FEMALE: 3b. Was decedent pregnant past 12 months? 1 Yes 2 No 9	in the 1	Unknown	at time of d	2 Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followship Followshi	etal death			pregna		B	3d. Date of deliv Month	Day Year		
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Division Hospital or Attend 24 house steer death Funeral Birrector:	Certification:	3 Suicide 6	nvestigation Could not be determined	28e. Place of	Injury - At	home, farm, str	eet, factory	, office b	ouilding, et	tc.	28f. Location or Town,			Rural Route Number, C	ity
Divisior To the Hospital or Attend within 24 hours after death. To the Foureral Director: completely filled in by the	ज़	29a. Certifier 1 Certifyin	Examiner: Or	the basis of e	camination	edge, death occ and/or investig	urred at the	time, da opinion	ate and plant, death oc	ace, and	I due to the ca at the time, da	use(s) a te and p	and manner as solace, and due to	tated. the cause(s)	
To Cor	Me	29b. Signature and title of ce		d manner state	v		290	O.C.	e number				d. Date signed (oril 28, 2009	Month, Day, Year)	
	-	30. Name and address of pe		pleted cause o		em 23a) 1 Penn Stre	eet, Balti	more,	MD 212	201					
Sta Registr	te	31. Date filed (Month, Day, Y				ature park	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7,8,10e,19b, perfil 8891 5/20/09 TT

Amend Items 23 and 11,11,125,27,28 are ment of Health and 11 tems 23 and 11,125,27,28 are ment of Health and 11 tems 23 and 11,125,27,28 are ment of Health and 11 tems 23 and 11 tems 23 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 and 12 tems 25 1 - For A State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April 17, 2009 **Physician** 2:44pm Claudine G. Francois /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1935)
Nov 25, 1938 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs Belgium Director 74 579-86-0752 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Evanings must be notified at Yes 2 No MD Montgomery Bethesda Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20816 5414 Duvall Dr Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) French Teacher Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linky or other traumatic event, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marthe Marie Glavany Andre de Ryckman de Betz Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5415 Duvall Dr, Bethesda, MD 20816 Christian Francois/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State Ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-22-09 Silver Spring, MD 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature/of Funeral Service Licensee Jauce 131 5530 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Subdural Hemorrhage with Complications Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident WHOM USPROMED BY MEDICAL EXPLANATE /Medical Due to (or as a consequence of): **Examiner** Sub dural Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transi Coronary Artery Disease and Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Chronic obstuctive pulmonary Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ Coronary Artery Disease, Chronic Obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No **Director:** After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) 1X Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending February,2008 Unknown Subject fell 2 X Accident investigation 1 ☐ Yes 2 X No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5414 Duvall Drive 4 Homicide Home Bethesda,MD To the Hospital within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) louatchou, ms 2006374X Jocellyne April 18,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mills Rd, Rockville, MD M.D. Jocelyne Kouatchou, 31. Date filed (Month, Day, Year) Registrar's Signal

State Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 26 200 year 4:06 pm Charles Raymond Goldsmith /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mechanicsville Saint Mary's 40051 Mrs. Graves Road If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jul 08 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months **M** M 2□ F Director 220-32-6817 1937 Maryland 71 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director Mechanicsville Saint Mary's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or 3 dical Examiner must be n 20659 USA 40051 Mrs. Graves Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No. 1 9 5 4

If Yes, Give Year or Dates: 1 9 6 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 1962 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpet Layer Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumaths wown. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Leroy Goldsmith Eleanor Richards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Goldsmith/Wife 20659 40051 Mrs. Graves Rd. Mechanicsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial 4 ☐ Donation 5 ☐ Other (Specify) 5/1/09 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home Off M00902 2294 Old Washington Rd. Waldorf, MD. 20601 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a CHRONIC OBSTRUCTIVE PULMONARY DISEASE years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3X Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Nas autopsy performed? 2∏ No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0014168 April 29, 2009 auc7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B51 Bauer Three Notch Road Mechanicsville, MD. 20659 Robert 28103 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 29 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 9 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:25 P M 2009 Arthur Finley Geesaman, Jr. Apri1 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 61 South Edgewood Dr. E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F Months Hours Director 222-10-6522 80 Sept. 26, 1928 Delaware Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō traumatic event, the Medical Examiner must be or items 23a 61 South Edgewood Dr. 21921 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Construction and Mental Hygie is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Finley Geesaman, Sr. Violet Elizabeth Smith ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Carol Geesaman/Wife 27 61 South Edgewood Dr., Elkton, MD other t 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 05-01-2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 22. Name and Address of Facility
R.T. Foard and Jones, Inc.
122 West Main St., Newark, DE Signature of Funeral Service Lic rehard 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: Director: within 24 hours a To the Funeral I

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death account of the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of ceptifier 29d. Date signed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

one)

29b. Signature

(Check only

31. Date filed (Month, Day, Year)

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Per me, g891,05/11/09dhb Certificate of Death Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** April Elmer R. Hicks 17**,**2009 11:46A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July28,1929 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral X**□ M 2□ F Months Days Hours Min Director 79 Kentucky 286-24-8211 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 □ No Huber Heights Ohio Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 45424 U.S.A. Funeral <u>6015 Seagate Place</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No 1951 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 127 Yes 2 No 1951 If Yes, Give Year or Dates: to1953 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify þ Specify: 3 ☐ Widowed 4 🙀 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Ite Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Huber Homes, Inc. 4 Rental Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Thomas Roy Hicks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Lamb/Daughter 4226Sweetleaf Lane, Edgewater, Maryland21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MemorialParkCemetery4-23-09 Dayton, Ohio 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Marzullo Funeral Chapel, P. A 6009Harford Road, Baltimore, Maryland21214 Michael margulle 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. pproximate Iterval Between Inset and Death WEEKS Do not enter the mode of dving Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Fa11 Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Worknown To the Hospital or Autonomics within 24 hours after death.

To the Funeral Director: After this certificate has been in the Funeral Director, and the funeral director, page 2 should be a supplemental director, page 2 should be a supplemental director. Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 D 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes -2 Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 2 K Accident April,2009 1 ☐ Yes 2 K No Unknown ^M Subject fell. 6 ☐ Could not be 3 Suicide Ref. Location (Street and Number or Rural Route Number, City or Town, State) 6015 Seagate Place Huber Heights, Ohio Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide Home, TIL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and ma ner stated. te of certifie 29b. Signature and 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person death (Item A3a) (Type, Print) 2

State

Registrar

31. Date filed (Month, Day, Year)

1 1 2009

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32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 2009 MARY MARGUERITE HENDERSON PM 7:42 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 1 □ M 2 1 F 216-82-6354 51 2/6/1958 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Frederick Burkittsville 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5008 Old Brownsville Pass 21718 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Henderson Mabel Weedon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Weedon (Sister) 400 Braddock Ave., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 ☐ Rentoval from State AME Cemetery 4 Donation n 5 □ Other (Specify) Fundral Service License 4/30/09 Burkittsville, 22. Name and Address of Facility Donald B. Thompson Funeral Home Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gostrointestinal Due to (or as a consequence of): Gastric Sequentially list conditions, if any leading to initial decause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 1 ☐Yes 2 ☐No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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23a

items

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Wedfarl Event

Baltimore, Maryland 21215-0036

Medical Exercitive roust be notified at

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death with the Maryland

Examiner attending physician and for use as the burial-tran signed by the a d be detached fo been si should l page 2 s After this certificate has director,

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

the Hospital

death.

Physician/Medical þ Completed Be ၉ funeral Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the

9 Unknown

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 □ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signat and title of certifier MC

29c. License number D0067210 29d. Date signed (Month, Day, Year) 25

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ROHIT KNIRS AT 400 W 7+W 57. FACOURSEL MA

State Registrar

31. Date filed (Month, Day, Year) APR 29 2009

29a. Certifier

ca Med

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item Registrar	State s s 23aPtI	of Maryla ,25 per	and/Depa r me,g89	artment of 1.05/11 rtificate of	Health ai 09dhb <i>Death</i>	nd Mental Hy	giene _{Reg. No} 200	9	15486
	Physic		1. Decedent's Name (First, Middl						2. Date of De	ath	V	3. Time of Death
	/Medi		Richard Gray	Jordan					Month Apri	1 20, 200	Year 09	M q 00:8
	Exami	ner	4a. Facility Name (If not institution Holy Cross Hospita		umber)		4b. City, Town, Silver		Death	4c. County of Montgo		
E	Funeral Director		5. Social Security Number 219–46–6900	6. Sex 1 X M 2 ☐ F	7. Age (In)	vrs. last birthday) 61 Yrs.	If Under 1 Year Months Days		Min. (Month, Da	th ly, Year) 13, 1947	9. Birthpla Countr	ace (State or Foreign y) DC
	put ,		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo					140	
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	the the same same same same same same same sam	Director	10e. Street and Number	Official		211	ver Spring			10g. Citizen of Wh	nat Countr	
	h with	a D	12101 Arbie Road				209	04		USA		, .
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show diest Examinations to collified at	Funeral	11. Marital Status 1 ☐ Never Married ②X Marr	Armed F	cedent Ever in orces?		Was Decedent of f Yes, specify Cu	Hispanic Origi pan, Mexican, i	n? (Specify Yes or No Puerto Rican, etc.)		- America , White, etc	
21215-0036	ural", or	þ	3 Widowed 4 Divorced	If Yes, G Year or	ive		1∐Yes 2 X No	Specify:	_	Specify:	Whi	te
15-	"natu	lete	15. Decedent (Specify only highes	's Education of grade completed)	(Give	dent's Usual Occu kind of work done	durina most o	f working	16b. Kind of Busi	iness/Indu	ıstry
212	d within 72 he giene. er than "natu , the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire rity Tech	,		Survei	.11ance	e
Maryland	12 should be filed w hand Mental Hygiel and Mental Hygiel is marked other tranmatic event, in	To Be (17. Father's Name (First, Middle, Ralph Pyott Jo	,				2.4	Name (First, Middle, Daret Gray	Maiden Surname))	
ary	shoul and M s mar	-	19a. Informant's Name/Relationsl	nip (Type. Print)		19b. Mailin	g Address (Stree		or Rural Route Numbe	er, City or Town, S	tate, Zip (Code)
	and 2 ealth n 27 i		Jayne Purcell Jord	an / Wife		12101	Arbie Ro	ad, Silve	er Spring, MI	20904		
ore	t of H If iter or oth		20a. Method of Disposition 1 □ Burial 2 🏿 Cremation	3 ☐ Removal from	State 20t	o. Place of Dispos cemetery, cren	sition (Name of natory or other pla		Date	20c. Location - C	ity or Tow	n, State
Baltimore,	rtmen rtmen rtant: njury		4 □ Donation 5 □ Other (S)	ecify)	Me	etropolita		-y ; -	ril 21, 2009	Alexandri	a, VA	
Ba	permit. Pages 1 and 2 should b Department of Health and Ment Important: If item 27 is marked any injury or other traumatic e once.	9	21. Signature of Funeral Service	Cole			Name and Addr Francis J 500 Univer	. Collins	s Funeral Hom d. West, Sil	e Inc. ver Spring	, MD 2	20901
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5	Physician	ì	Immediate Cause (Final disease or condition resulting in death)	-	umonia						- (Onset and Death
	/Medical Examiner				(or as a cons	equence of): iratory Di	stress Sa	vdromo		./	, .	
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)	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	cDru	g Induce	d Interst	itial Pneu	monitis	0.0	W MEDICAL EX		
58760,	ficate be executed physician and s the burial-transit		resulting in death) Last		(or as a cons eatment	equence of): for Pre	ostate C	ancer	CONFIGURAL SPROM	90		
89	tificate ig phy as the	edical		d	_				ENTRICATION			
Вох	eath certific attending p for use as f	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of preg		Ectopic pregnan			23d. Date	of delivery	,
0	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time of		Other (specify)			Monti	h D	ay Year
۰, ۳.	es that igned b	by Pr	Part II. Other significant conditio	ns contributing to d	eath but not r	esulting in the un	derlying cause gi	ven in Part I.	23e. Did to	bacco use contrib	ute to the	cause of death?
ord	w require s been siç should b		Prostate Cano	er					1 🗆 Y	es 2 X No 3	☐ Probat	oly 4 🗌 Unknown
3ec	e law r has be e 2 sh	Completed							24a. Was autop	sv I pri	or to comp	y findings available pletion of cause of
a	sician; The certificate h rector, page		05.00						perfor 1 🗆 Yes	m <u>ed</u> ? dea	ath? □Yes 2	XX No
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Sio	endin sath. NZ: Af hR fur	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	ation	th, Day, Year)	Injury	M 1	rk?]Yes 2□No				
Division of Vital Records,	or Att after de Directe in by t	Certification:	3 ☐ Sulcide 6 ☐ Could no 4 ☐ Homicide determin	20e. Place	of Injury - At ing, etc. (Spe	home, farm, stre	et, factory, office		28f. Location (S City or Tow	itreet and Number n, State)	or Rural F	Route Number,
	ospital hours uneral		29a. Certifier 1 X Certifying	Physician: To the	best of my k	nowledge, death	occurred at the t	me, date and	place, and due to the	cause(s) and man	ner as sta	ted.
:	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certified completely filled in by the funeral director, to	Medical	29b. Signature and title of certifier	and man	ner stated.	madon and/or inv	estigation, in my	opinion, death	occurred at the time,			
•				01/1	V Kn.	m		126	152	29d/ Date signed (Month Da	ay, rear)
1.	4.		30. Name and address of person w	no completed care	se of death (It	em 23a) (Type, P	Print)			101/		
(2)	0)		Bradley Bennet					Silver Sp	oring, MD 209	002		
	Stat Registra	~	31. Date filed (Month, Day, Year) APR 23 2	1009 Jun	legistrar's Sig	a far	المسك					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:14 AM 2009 April 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WASHINGTON WASHINGTON TOSP ITAL HAGERSTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year 1 □ M 2 KF 170-30-4113 Director GETTYSBURG, PA 1938 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Expriner rust be notified at once. **Funeral Director** 1 ☐ Yes 2 No PA GETTYSBURG ADAMS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 17325 KNOXLYN - ORRTANNA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LYDE CURRENS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUSTICE KNOXLYN-ORRTANINA RP 585 GETTYSBURG PA ĴERRY TUSDAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Semoval from State -24-09 LAWN MEMORIAL GARDER. ZETTYSBURG, PA 4 ☐ Donation , 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee anover PA 17331 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami sician and burial-trans Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12-months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) P.O. detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes To the Hospital or Attending Physician: After this certific funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 17 Yes 2 □ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Dm. 1 ☐ Natural 2 ☐ Accident 5 Pending investigation Motor within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 20 wille 09 1 ☐ Yes 6 ☐ Could not be 3 ☐ Suicide e of Inury - At home, farm, street, factory, office ding, i.e. (Specify) determined 4 Homicide Roadway Chambersburg, PA 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signatur 29c. License number 440884 29d. Date signed (Month, Day, Year) 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) 21740 nomas 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar park

Amended Items 28b,28e,28f per M.E. 04/23/2009 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** MEREDITH íK. April 2009 1232 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2 □ F Months 218-40-7193 Yrs Jan 2, Director 62 1947 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f shov Director 1 X Yes 2 ☐ No MD Worcester Whaleyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11829 Steam Mill Hill Road 21872 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Exempt 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 TXNo Specify: Specify: Black \$ 3 ☐ Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Trooper Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Purnell Paulyne Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia White/sister 6422 Stargaze Lane, Charlotte, NC 28269 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pulletts UMC Cemetery 4/28/2009 Whaleyville, MD 21. Signatur of Funeral Service Linguisee ²² Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Road, Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 'on a estive Immediate Cause (Final Severe failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical certificate attending ph 15 4122/09 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate performe Vital 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death

Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D58755 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009

State Registrar 31. Date filed (Month, Day, Year) 32. Re APR 2 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

C+/7/1 800

MERRITHTORS

GLENN K. ARZAPON MD9714 HEALTHWAY DIZ; BERLIN MD 21811

Amended Item 23a per Phy. 04/28/2009 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 3. Time of Death Month Year **Physician** 9:07 AM Joseph Korclesti 2009 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical levice Laltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 Ø M 2 □ F Months 215-54-2540 58 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the "Acceleration of the matter manning once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll New Windsor 1 ☐ Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 USA 2313 Overbrook Drive by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 【★Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration Systems Analyst 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Loretta Moran Joseph Thomas Korcheski P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2313 Overbrook Drive New Windsor, MD 21776 Karen Korcheski/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD Lakeview Memorial Pk 4/25/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal ir a of Fun all Service Licensee Printed Admeradia Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sever vascular 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Man er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Il Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide determined the Hospital 1 🗹 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 5 29c. License number 29d. Date signed (Month, Day, Year) 1 MO 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brenner 22-56/182 50 Bolt, MORE, HOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Day Alice R. Krasnesky April 11:15a[™] 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Westminster Carroll Social Security Number 6. Sex 7. Age (In yrs. last birthday) 71 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Director 215-34-1567 8/19/1937 MD Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Event has must be mailled as Director 1 ☐ Yes 2 ☐ No MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4418 Black Rock Road, Apt. 4 21074 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 ∏No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: white <u>۾</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) game shipper game factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Neidewermmer Margaret Irene Lodato ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Roberts, son 4302 Black Rock Rd., Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation 4/28/2009 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Handa semmer 934 S. Main St., Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** septic shock 24 hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** myeloproliferative disease 4 mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in ilitated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit myelofibrosis 1 wk Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ acute renal failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed: 2 🗆 No 1∐Yes 2√∏No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**∕**∑ No Certification: To 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

WIL 4

> State Registrar

Medical

4 Homicide

(Check only one)

30. Name and ad

29b. Signature and title o

Rajpara,

31. Date filed (Month, Day, Year)

certifie

M.D.

29a, Certifier

Washington Hts., Westminster, Md.

and manner stated.

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

224

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Perstate of Maryland/Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician MARY JUNE KERSHAW MAY 2009 1:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21401 Allens Lane Rock Hall Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 13 1923 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 576-64-3422 **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 85 Yrs 575 60 New Zealand **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exprendent must be notified at once. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director Kent. Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 Allens Lane Funeral 21661 New Zealand 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 212 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Charles Frederick Baker Winifred Thompson Williams ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Rex Kershaw (husband) 21404 Allens Lane Rock Hall, MD. 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kent Cremation 5/8/09 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or es a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed 1 ☐Yes 2 No this certifical Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5/8/09 12388

DHMH 17 Rev 1/2001

DIL

State

Registrar

Chestertown, MD. 21620

223 High St.

32 Registrar's Signatur

anna.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Arrabal, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23aPtI,25 per me, g891,05/11/09dhb Seg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 625 P M Barbara M. Lessig 13 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery Date of Birth (Month, Day, Yea 9/29/33 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 162-28-0475 75 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Ever it and the notified a 1 XYes 2 No Director MD Montgomery Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with in and Mental Hygiene. 21000 Georgia Avenue 20833 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. ۾ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Antiques Dealer/Appraiser Retail Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James R. McIlrath Myrtle N. Nolle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is rr any injury or other traum once. 21000 Georgia Ave. Brookeville, MD 20833 James B. Lessig, Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Brentwood, MD 4 Donation 5 Dother (Specify) Fort Lincoln Crem 4/17/09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, / r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate caus. (Final disease or fondition resulting in eath) Physician Multisystem Organ Failure 3 days /Medical Due to (or as a consequence of): Bronchiolitis Obliterans Organizin Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunonicia Pneunon Examiner 3 weeks Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed 3 weeks physician and s the burial-trans Due to (or as a consequence of) Box 68760 Therapy for Refractory Atrial Fibrillation Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year P.O. the 9 Unknown 9 ☐ Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No certificate has page 2 1 □ Yes 1 ☐Yes 2 🖾 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 210 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 ☑ Natural 2 ☐ Accident 5 Pending n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0035045 April 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip G. Henjum, MD 18109 Prince Philip Drive #200 Olney, MD 20832 31. Date filed (Month, Day, Year) 2 Begistrar's Sign State 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. Ne. UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April 25, Day 2009 Year **Physician** Howard W. Leaf 7:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 16002 Doctor Bowen Road Brandywine 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) iplac untry) M I 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 X M 2 □ F Months Hours Yrs 1923 Director 85 September 22, 353-18-3384 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo <u>Maryland Prince Georges</u> Brandywine 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA Funeral 20613 16002 Doctor Bowen Road 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Air Force 12th. Lt. General Masters 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Hilda Olsen Joseph Conrad Leaf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or other trau 16002 Doctor Bowen Rd. Brandywine, MD. 20613 Madonna Leaf/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 14, 2009 Arlington, VA. Arlington Nat. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 MUISAH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carcinoma of Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 s performed: autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) APR 29 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cutu

Martin D. Weltz 7525 Greenway Center Dr., Greenbelt, MD. 20770 32. Registrar's Signature

D23743

4-27-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** Margaret Erb Mann 4:35 p April 23, /Medical 4b. City, Town, or Location of Death Westminster 4a. Facility Name (If not institution, give street and number) 4c. County of Death Carroll Examiner 265 W. Main Street 8. Date of Birth (Month, Day, Year) Oct 16, 1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Min. Months Days Hours Maryland 1 □ M 2 X F 213-38-5239 95 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Westminster Director Maryland Carroll 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 265 W. Main Street USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 No white Specify: Specify: ģ 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Teacher/Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be N. Claude Erb Mary Elda Byers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2830 Old Washington RD, Westminster, MD 21157 Margaret Bostic, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Calvary Methodist Cem 4/28/2009 Gamber, MD 4 Donation 5 Dother (Specify) Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2/No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 □ No

Box 68760, P.O. Division of Vital Records,

requires that the death certificate be executed burial-transi and attending physician for use as the burial been signed by the should be detached page 2 should has this certificate or Attending Physician: director, funeral After death.

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exering roust be nutfied at once.

Physician

/Medical Examiner

3altimore, Maryland 21215-0036

ithin 24 hours after death.

• the Funeral Director: A

ompletely filled in by the fu the Hospital

6 Could not be

determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day, Year)

To the I within 2. WJL 10

Medical

State

Registrar

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

ligation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

			. For					Health and M	-		egible.	15105
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	Physici	an	Decedent's Name (First, Middle, L						2. Date of Dea	Day	Year	3. Time of Death 18:20 P M
	/Media	cal	Doris Pressman 4a. Facility Name (If not institution, gi		mber)		4b. City. Town. o	or Location of Death	5	6 4c. C	2009 ounty of Death	
2	Examir	iei	FROSTBURG VILLAG			ar D	FROSTBU				LEGANY	
5	Funeral		5. Social Security Number 6.	Sex 1 □ M 2 💢 F	7. Age (In yrs. 7 (last birthday)			8. Date of Birt (Month, Da	th y, Year)	9. Birth Cou	place (State or Foreign Intry)
	Director		220-30-8141 Usual Residence of Decedent		/(Yrs.			08-08-	1932	MAR	YLAND
	ryland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	8a-1 s	Director	MD ALLEGA	NY	CUI	MBERLA						1 Yes 2 No
	ath with the Marylan 23a or 28a-f show		10e. Street and Number	DOAD			10f. Zip Code 21502			10g. Citize	en of What Cou	intry?
	72 hours after death with the Maryland natural', or Itema 23a or 28e-f show disal Examinar mast be notified at	Funeral	13301 WINCHESTER 11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.		dispanic Origin? (Sp an, Mexican, Puerto			. Race - Ameri	
98	or Ite		1 Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 No		1 ☐ Yes 2 ☑ No	an, mexican, Pueno Specify:	Hican, etc.)		Black, White	
8	hours tural',	ed by	3 Widowed 4 □ Divorced 15. Decedent's 6	Year or D	ates:		dent's Usual Occup				of Business/Ir	ITE
215	be filed within 72 hours after dea ntal Hygiene. nd other then "natural", or Itema event, I're Medical Examinat na	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1	40r 5+)	(Give	kind of work done DO NOT use retire	during most of work	ing	TOD. KING	1 Of Bu3#1635/11	luustry
21	filed within Hygiene. ther then "	Com	12		-401 34)	HOUS	SEKEEPING				ERS TTY	
and	ould be fil Mental H arked oth	Be	17. Father's Name (First, Middle, Las JOSEPH WARD	st)				18. Mother's Nam			umame)	
Maryland 21215-0036	should ind Men marke umatic	ို	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailii	ng Address (Street	and Number or Rur			Town, State, Zi	ip Code)
	d 2 h a 7 ts		CINDY BEELER	DAUGHTER	}	13303	1 WINCHES	TER ROAD	CUMBERL	AND,	MD 215	02
Baltimore,	Pages 1 and nent of Heali int: If Item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from	State	cemetery, crei	osition (Name of matory or other pla	ce)	Date		ation - City or T	
Ē	Pa ant: ury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	ify)	CU			ORY 5-9-2			ERLAND,	
Ba	permit. Departr Imports eny inju		Jan M. Guero		00547	61	TO MATE	SOW	ERS FUN	ERAL	HOME,	P.A.
	- X (\$)		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that c	aused the dea	h. Do not ent	ter the mode of dyi	ST., FRC	or respiratory ar	rest,	21332	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			erotro	c cardi	ovascul	lar di	reug	e	Onset and Death
	/Medical Examiner		resulting in death)		or as a consec							
8	* * * * * * * * * * * * * * * * * * *	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	or as a consec	juence of):						
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687	physicate to physical	edicai		d								
Вох	death certifica e ettending ph ed for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		75.4			23	d. Date ol deliv	/ery
. B	0 0	by Physician/Medi	in the past 12 months?		ant at time of		⊒Ectopic pregnanc ☐ Other (specify) _	,			Month	Day Year
P.0.	thet the de led by the e detached f	Phy	9 ☐ Unknowfi Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderiving cause giv	ren in Part I	23a. Did to	obacco use	contribute to	the cause of death?
rds,	v = 0	d by	Endstage	Renal	dise	ise	,					bably 4 Unknown
000	he law require s has been sig ge 2 should b	Completed							24a. Was			opsy findings available
ž		Com	100						autop perfo 1 Tes	rmed2	death?	ompletion of cause of 2XNo
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			- 2 DOA O#	26. Place of Deat				
o	y Phys ar this eral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o	IL 3LI DOA	4 Nursing Ho	me 5 Resid			ify)
ion	vttending death. ctor: Afte y the fun	atio	1 Natural 5 Pending 2 Accident Investigate	on	h, Day Year)	Injury		rk? Yes 2 □No				
Division of Vital Records,	l or Atte after de Directo	Certification:	3 Suicide 6 Could not 4 Homicide determined	288. Place	of Injury - At h	ome, larm, str	eet, lactory, office		281. Location (S City or Tox	Street and i	Number or Rur	ral Route Number,
	Hospital or Attending 24 hours after death. Funeral Director: After tely lilled in by the fune		29a. Certifier 1 Certifyin 1 P	hysician: To the	heet of my kno	wled a death	h occurrent at the ti	ne, date and place,	wall than to the c	en a consideration and		ator - 1
	To the Hospital or Attending Physician: within 24 hours after deals To the Funeral Director: After this certific completely lilled in by the funeral director,	edical										
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Month,	, Dey, Year)
•			workoller	elle	MI)	D	0055325		Ma	y 07,	2009
			30. Name and address of person who WONSOCK SHIN	completed caus	e of death (Iter	Wals	h Rd 1	ambarla	end is	102	102	
	Sta		31. Date liled (Month, Day, Year)	32. R	egirtrar's Signa	ature 6	backer	pointion, death occurring number			_	
	Registr	ar	MAY 1	3 2009	Cenwa	p. 1	and the same					

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 2 🔀 No

Approximate
Interval Between
Onset and Death

48 hours

Year

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0033 AM

Division of Vital Records, hours after death.

Ineral Director: After this
y filled in by the funeral dii e Funeral To the I within 2 WIL 10

4 Homicide

29a Certifier

Medical

State

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064732 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL AVE. Martin Britos WESTMINSTER. MD 200 31. Date filed (Month, Day, 32. Registrar's Signature **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:13 AM Barbara Α._ Reeves May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 M 2/C)(F Yrs. Director July 20, 1953 Maryland 219-60-3752 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f eho 'traumatic event, the Madical Experiment per molified at 1 Yes 2 No Directo MD Darlington Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 Shuresville Road 21034 u.s.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Tanchuk Gertrude Husvar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Reeves (Husband) 2201 Shuresville Rd., Darlington, Maryland 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. Inc. 05/07/2009 West Chester. PA 21. Signatur 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Acute /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown BARBARA Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes No 1 Tyes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27_Manner_of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after death
To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the hest of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner at etated 2 Medical Examiners. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D0063981 May 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havrede Grace, Mp 21078 669 Revolution St MD Benjamin Lee, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3 2009 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mar Virginia A. Richards /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Litizens Care + Rehabilitation C Havre De Grace Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2**V**□ F 83 Maryland Director 02/03/1926 216-20-9097 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Havre de Grace Director MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be 23a U.S.A. 122 Bluebill Court 21078 the Medical Examiner must 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Bace -'natural", or items 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Fox Harry Arbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Jenniser Richards (Daughter) 122 Bluebill Ct., Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co. Inc. 05/07/2009 West Chester, PA Signature of Funeral Service License 22. Name and Address of Facility Zellman Funeral Home, P.A. 23 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine and burial-trar that initiated events resulting in death) Last Box 68760, attending physician certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mon for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital/Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 □ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has bairector, page 2 s autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2000 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir After this 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

who completed cause

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31. Date filed (Month, Day,

09-03356 Robert E. Rothhaas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Ma	ryland / Depart	tment of Healt	th and Mental	Hvaiene

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en E. Rou		1- For State Criticate of Death Registrar	Reg. No. 2. Date of Death 3. Time of Death				
Physic I Exam		1. Decedent's Name (First, Middle,Last) Robert E. Rothhaas	Month April 26, 2009 Year 1522 hrs				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Anne Arundel Medical Center Annapolis	Location of Death Anne Arundel				
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 283-54-4899 1 XM 2 F 42 Yrs. If Under 1 Year Months Days	(COUNTRY)				
vith the Maryland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 X No				
	Director	Maryland Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 4923 Beech Street 20764	10g. Citizen of What Country?				
5-0036 led within 72 hours after death with the Maryland Hygiene. other (han "natural", or items 23a or 28a-f she	Funeral Di	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His 14. Never Married 3 X Married Armed Forces? If Yes, specify Cubar	spanic Origin? (Specify Yes or No- h, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.				
urs after des tural", or i	d by Fu	3 Widowed 4 Divorced It Yes, Give Year Dr. Dates: 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed)	tion (Give kind of work done 16b. Kind of Business/Industry				
11215-0036 Id be filed within 72 hours after de dental Hygiene. narked other (han "natural", or	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Statistician	Census Bureau 18. Mother's Name (First, Middle, Maiden Surname)				
21215-0036 within 7 Mental Hygiene.	Be Co	17. Father's Name (First, Middle, Last) Ronald Rothhaas, Sr.	Eileen Jones				
MD 21215 id 2 should be fill lith and Mental H	umafic eve	Cynthia Ann Rothhaas/Wife 4923 Beech St	et and Number or Rural Route Number, City or Town, State, Zip Code) reet, Shady Side, Maryland 20764 emetery. Date 20c. Location - City or Town, State				
s 1 and of Heal	or other traumatic		hurch 05/01/2009 Owensville, Maryland				
Baltimo permit. Page Department of Important:	injury o	21. Superure of Funeral Service Licensee 22. Name and Address 2973 So 1 on	nons Island Road, Edgewater, MD 21037 Such as cardiar or respiratory greet, shock, or heart Approximate Interval				
Physicia Medic camin	al	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause or each line. Immediate Cause (Final disease a. Hydrofluoric acid investion	Between Onset and Death				
	١.	or condition resulting in death) Due to (or as a consequence of): b. Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
p	nsit Fyamine	Couse Enter Underlying Councillose (Disease or injury that initiated events resulting in death) Last Councillose (Disease or injury that initiated events resulting in death) Last Councillose (Councillose of Councillose Of Councillo					
e execute	ial - tran	d. X UNPENDED AMENDED AMEND					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and	use as ti	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy 23d. Date of delivery Month Day Year				
P.O. Boss that the deal	should be detached for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I. 23e. Did tobacco use contribute to the cause of oeath? 1 Yes 2 No 3 Probably 4 Vunknown				
of Vital Records, Fig Physician: The law requires After this certificate has been sign	age 2 should be		24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No				
tal Recoltin: The law	funeral director, page 2		ce of Death (Check only one)				
Vita hysicia this ce	direct	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other, Nursing Home 5 Residence 6 Other:				
on of Vital I anding Physician: ath.	he funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Ir 1 Natural 5 Pending 2 Accident Investigation 3 Accident Investigation	yes 2 X No 28d. Describe how injury occurred subject ingested hydrofluoric acid				
Division To the Hospital or Attendivitin 24 hours after death. To the Funeral Director:	filled in by the fune	2 Accident Investigation 3 X Suicide 6 Could not be determined 4 Place of Injury - At home, farm, street, factory, office (Specify) home	28f. Location (Street and Number or Rural Route Number, City or Town, State) 4923 Beech St. Shady Side, MD				
To the Hospi within 24 hou To the Fune		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated. 29b. Signature and title of certifier 29c. Lice	on, death occurred at the time, date and place, and due to the cause(s)				
	00		onse number 29d. Date signed (Month, Day, Year) C.M.E. April 27, 2009				
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Bal	timore, MD 21201				
	Sta	24 Periotrar's Signature 4					

	Physicia /Medica						
	Exami						
Ţ	irector						
farylanc	f show	ō					

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho any injury or other traumatic event, I'm Medical Exa.cii art must be rediffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Atterwine St Atterview State deed to the Funeral Director Completely filled in by the

	1 - State of Ma		artment of Health and rtificate of Death		Reg. No. 2009							
ion	1. Decedent's Name (First, Middle, Last)			2. Date of De Month		3. Time of Death						
ian ical	Mary Gertrude Sturgeon			April	23 2009	1:00 P M						
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deal	th	4c. County of Death	1						
	Golden Living Assisted Livi		Westminster	Dolo (B)	Carroll	(Chata as Fasaign						
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Director	MD Carrier and Number		10f Zip Code		10g Citizen of What Cou	untry?						
ral Dir	10e. Street and Number 1234 Washington Rd		10f. Zip Code 21157		10g. Citizen of What Cou United State							
Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 11 □ Yes 2 ☑ If Yes, Give Year or Dates:	No. 1	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer 1 □Yes Ž™No Specify:	Specify Yes or N to Rican, etc.)	Specify: Whi	, etc. ite						
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ပြိ	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle	e, Maiden Surname)							
To Be	Arthur Sims		Ada Jon									
	19a. Informant's Name/Relationship (Type. Print) Carol Sturgeon (daughter-in-law) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. New Windsor, MD 21776											
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ria de la companya de	21. Signature of Europa Sortice Ricerson											
	23a. Part 1. Enter the disease, or complications that cause					Approximate						
	shock, or heart failure. List only one cause on each li Immediate Cause (Final	ine.		, ,		Interval Between Onset and Death						
	disease or condition a.	Varar	(ance			Years-						
1	Due to (or as	a consequence of):										
ě	Sequentially list conditions, if any, leading to immediate Due to (or as	Due to (or as a consequence of):										
Examiner	Cause (Disease or injury											
EX	that initiated events resulting in death) Last C Due to (or as	a consequence of):										
dical	d											
	IF FEMALE:					- WO						
Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year							
H.	Part II. Other significant conditions contributing to death I	out not resulting in the u	ınderlying cause given in Part I.	23e. Did	I tobacco use contribute to	the cause of death?						
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Completed				24a. Wa	is an 24b. Were au	utopsy findings available completion of cause of						
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ü	27. May er of Death 1 Natural 5 □ Pending 28a. Date of Inj (Month, D	ury 28b. Time o ay, Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe	e how injury occurred							
cati												
ertifi	3 Suicide 6 Could not be determined 28e. Place of In building, e	ury - At home, farm, street, factory, office c. (Specify)		281. Location City or T	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Me	29b. Signature and title of certifier		29c. License number	2 7	29d. Date signed (Mont	th, Day, Year)						
	30. Name and address of person who completed cause of	noste	MADON	× 0								
		trar's Signature	St307 West	rinste	1000 211	/						
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